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**(Re)collections: Engaging Feminist Geography with Embodied and
Relational Experiences of Pregnancy Losses**

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Abstract

With empirically-grounded and theoretically-inferred consideration in this thesis, I bring into focus a vast ‘collection’ of components entailed in lived experiences of pregnancy losses and, in particular, foreground the ways in which spaces and places are intimately involved. This includes, for example, attending to medical settings such as hospitals, workplaces, homes and gardens, online support communities, cemeteries and other memorial locations in addition to bodies which are simultaneously material and emotional. Since pregnancy losses are inter-personal, I also discuss social relations between women, their embryos, fetuses, babies and/or children, medical staff, partners, family members, friends, work colleagues, online group users and ‘wider society’.

The multiplicity of components within, and across, participants’ experiences serves to simultaneously break apart and reassemble the label I selected for the research of ‘pregnancy losses’. I utilise several sub-disciplines across the thesis, finding a particularly significant and tricky tension between two particular areas I wish to engage: feminist geographies and the geographies of death and dying. My research weaves together feminist, embodied, emotional geographies through which I seek to understand experiences of pregnancy losses. In doing so, I foreground the richness, depth and complexity of lived experiences by developing understandings of pregnancy losses which embrace, rather than sanitise or marginalise, bodily materiality and social relations as well as emotional dynamics.

My thesis serves to bring together and explore the recollections of pregnancy loss experiences, organised around a number of spatial contexts and activities. These are reflected in the focus of each chapter in terms of interior bodies, social relations, bodily fluids, online sites, external skins and practices of memorialisation. My discussions work to ‘collect’ together understandings about the somewhat paradoxical fullness and variety of accumulated meanings that can be held about pregnancy loss experiences.

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Introduction

“Written on the body is a secret code only visible in certain lights;
the accumulations of a lifetime gather there”

Winterson (1996 p89, from the novel ‘Written on the Body’)

Pregnancy losses are experiences comprised of multiple bodies, emotions, materialities, social relations and meanings, and, as such, are much more than simply medical ‘events’. Through the lens of my disciplinary affiliation as a geographer, I seek to respond to Layne’s (2003a p239) call that “[f]eminists must frankly acknowledge the frequency and import of such events in women’s lives and create a woman-centered discourse of pregnancy loss”. My research engages with narratives about pregnancy losses to consider a variety of embodied, visceral, emotional and relational aspects. With empirically-grounded and theoretically-inferred consideration, I attempt to bring into focus the potentially vast ‘collection’ of components entailed in meanings of ‘loss’ and foreground the ways in which ‘spaces and places’ are intimately involved in pregnancy loss experiences. In addition to bodies as simultaneously material and emotional spaces, this includes: medical settings such as hospitals, Early Pregnancy Units (EPUs) and General Practitioner (GP) surgeries; homes and gardens; online sites; workplaces; cemeteries and other memorial locations. To focus solely or primarily on the emotionality of pregnancy losses, as I suggest much existing pregnancy loss research has, risks neglecting the physical body. My research will emphasise that “the physical and mental state of the body, its fleshy reality, is central” (Hall 2000 p28) to understandings of pregnancy loss.

The argument that academic research has largely overlooked pregnancy losses, and that this is reflective of but also potentially contributory to wider social dismissal, has been made prominently by Layne (1999, 2000, 2003a, 2003b) amongst others (Peppers and Knapp 1980; Reinhartz 1988; Cecil 1996). Pregnancy loss grief is now well established in the academic literature and a number of UK charity-organisations have relatively prominent public profiles, including Sands (Stillbirth and Neonatal Death Society) and MA (The Miscarriage Association). Subsequently, there is also growing recognition of these experiences within the public domain as statistically frequent yet potentially devastating occurrences (Letherby 1999; Moulder 2001). Yet, dismissive or hostile modes of ‘grief policing’ (Walter 1999; Small and Hockey

2001) for pregnancy losses remain for many, conveying expectations that ‘appropriate’ or ‘normal’ grief is brief (if at all necessary) and mourning discrete (private and quiet). Pregnancy losses ‘breach’ particular societal norms, expectations and linear trajectories, and are often responded to with invalidation and/or blame by social others such as by family members, friends, medical staff, and work colleagues. Social circles frequently retract socially-produced conferment of ‘baby’ and accompanying parental identities, despite their prior participation (Lovell 1983; Murphy 2012a). Subsequently, there tends to be a dearth of recognition, support and consideration regarding pregnancy losses, which stands in marked contrast to the often intense interpersonal interest in ongoing pregnancies (Longhurst 1999, 2008).

This introductory chapter will outline the framework used in my research, drawing on aspects of existing academic literatures which I have identified as significant. I will firstly elaborate on my use of the term ‘pregnancy loss’ which signifies openness to the multiple material and emotional interpretations. Following this, I will discuss the relationship between feminist research and pregnancy loss to highlight some of the tensions entailed, including that of foetal personhood. I will then outline the ways I situate my interest in pregnancy loss experiences in relation to the discipline of geography, before offering an overview of the structure for the thesis.

Defining ‘Pregnancy Losses’

I chose the umbrella label ‘pregnancy losses’ in my research owing to its amenability to different interpretations and contexts, permitting “an approach that is non-hierarchical in that it does not try, or want, to categorise experiences of loss in a way that some might be seen as more ‘serious’ or more ‘traumatic’ than others” (Earle *et al* 2012 p2). Subsequently, a variety of physiological and medical circumstances featured in my research: chemical, early, ectopic, anembryonic, missed and/or late miscarriages (<24 weeks); terminations (early and elective, as well as one late following positive prenatal diagnosis); prepartum stillbirth (>24 weeks, officially/legally recognised as deaths) and early neonatal death (<one week after birth). Medical classifications, however, do not adequately convey the complexity within and across circumstances, since “[w]omen miscarrying at the same gestational stage can react very differently depending on their own definitions of the experience” (Moulder 1994 p66).

The ways pregnancy losses are 'lived', understood and narrated are not merely matters of individual outlook or disposition but, rather, concern wider socio-cultural, historical, political and economic contexts (Malacrida 1999; Reagan 2003). The pervasive narrative of 'naturally'-achieved, medically-monitored pregnancies culminating in live births means that pregnancy losses in the contemporary Western context tend to be deemed both abnormal and unnatural (Layne 2012; Peel and Cain 2012). Subsequently, Layne (2003a) argues that pregnancy loss remains a taboo topic for discussion in society which, in effect, contributes to feelings of isolation and shame. Many who experience pregnancy losses, especially early losses, frequently encounter social responses of trivialisation characterised by dismissive comments like 'better luck next time' (Letherby 1999). As Layne (2003a) and Malacrida (1999) note, a plethora of seemingly minor aspects such as the lacking availability of specific 'Hallmark' sympathy cards can imply that miscarriages and stillbirths are not socially acceptable in terms of occurring, grieving or mourning. The cultural response of 'silence', often leading to emotional suppression and social isolation, continues to be experienced by many following their pregnancy losses (Davidsson Bremborg 2012; Gold *et al* 2012; Peel and Cain 2012).

Jenkins and Inhorn (2003) argue that research on 'successful' human reproduction has boomed in the social sciences in recent decades whilst 'reproduction gone awry' has continued to be comparatively neglected. This is surprising given the frequency of pregnancy loss occurrences, with an estimated quarter of pregnancies ending in miscarriage (The Miscarriage Association 2013a) and the UK stillbirth and neonatal death average rate of 17 babies a day (Sands 2013). There are also issues in the existing academic literature regarding which pregnancy losses have been researched and from which disciplinary perspectives this work has been conducted. Cecil (1996) comments that when she first began research on pregnancy loss, namely miscarriage, the topic was almost exclusively written about by psychologists and medical practitioners with very little contribution from social researchers. There have been calls and responses to rectify this omission, with Davidson (2007) noting a distinct strand in pregnancy loss literature during the 1990s of feminist research seeking to acknowledge women's experiences and validate their 'voices' (Simonds and Rothman 1992; Layne 1996, 1999; Letherby 1999; Malacrida 1999). Feminist scholarly commitments have thus been crucial to the production of a significant

proportion of the social research on pregnancy losses; however, this situation is not without tensions (Kevin 2011) and Layne (2003a p239) argues many feminists have instead “abandoned their sisters in hours of need”.

Much research on pregnancy loss originates from the domains of biomedicine regarding prevention, treatment and management of losses, and from psychology (Cecil 1996). Whilst these continue to be important, other kinds of knowledge with different disciplinary and theoretical underpinnings are also valuable. Qualitative work on pregnancy loss now exists in, for example, sociology, theology, philosophy, and anthropology. However, as will be discussed in more depth below, the discipline of geography has not produced much work on the lived experiences of pregnancy loss. This is despite the fact that some research from other disciplines has considered themes of space and place, such as Bleyen (2010, 2012) and Woodthorpe (2012). The profound emotional responses to pregnancy losses are prominently evidenced in both quantitative and qualitative research (Peppers and Knapp 1980; Lovell 1983; Toedter *et al* 1988; Goldbach *et al* 1991; Slade 1994; Slade and Cecil 1994; Layne 1996, 1999, 2000, 2003a, 2003b, 2004, 2006, 2012; Letherby 1999; Malacrida 1999; Zucker 1999; Kohner and Henley 2001; McHaffie 2001; Simmons *et al* 2006; Davidson 2007; Cacciatore *et al* 2008; Murphy 2009, 2012; Gaudet *et al* 2010; Rowlands and Lee 2010; Séjourné *et al* 2010; Davidsson Bremborg 2012; Gold *et al* 2012). Within this, it is frequently demonstrated that pregnancy losses are often incredibly distressing experiences for women, their partners and families, pertaining not only the *events* of pregnancy losses themselves but also particular *social responses* to these. This is not to preclude that a range of views and responses to pregnancy losses are possible, including relief and inconvenience (Reagan 2003; Keane 2009).

Throughout this thesis, I expand on a number of significant themes within the existing pregnancy loss literatures, such as the complexity of grief/emotions involved (Murphy 2009) and how pregnancy losses are often responded to by some social others with silence and/or trivialisation (Letherby 1999). In addition, I acknowledge that: some social others involved in pregnancy loss, such as partners (Puddifoot and Johnson 1997), are often overlooked (Chapter 4); that reproductive technologies like ultrasound (Moulder 2001; Peel and Caine 2012) and urine test kits (Layne 2010b) impact

on experiences of pregnancy loss (Chapter 3); and that many contemporary memorial practices suggest a shift to ‘continuing bonds’ (Silverman and Klass 1996; Woodthorpe 2012) from ‘severed ties’ (Chapter 8). Although only pregnancy losses at 24 weeks or more gestation are currently legally certified as deaths in the UK, earlier pregnancy losses may be considered as deaths by those involved regardless. Others prefer the word ‘loss’ or use it to additionally denote a range and collection of meanings. As Collis (2005) demonstrates in relation to hysterectomy, ‘loss’ can refer to: the physical organ; associated processes such as menstruation; the potential for children/childbearing; sexual desire; and ‘femininity’ or ‘womanhood’. Despite different understandings, vocabulary and definitions, social responses of silence and denigration of one’s emotions and responses can be experienced towards *all* forms of pregnancy losses.

Feminist Research and Tensions Regarding Embryos and Foetuses

It is likely that many feminist scholars, geographers included, have been reluctant to engage with the topic of pregnancy loss owing to contentious reproductive choice struggles (Layne 1999, 2003a, 2003b). As Kevin (2011) notes, different strands of feminism are relevant here: whilst the women’s health movement can be understood as a feminist endeavour in some ways (Burt Ruzek 1978), Layne (2003a, 2003b) argues that this has entailed overemphasising the happy outcomes of pregnancies as controllable, natural and joyful. Pregnancy loss events can undermine the efforts by women’s health movements to de-medicalise pregnancy by adding to:

the knowledge that birth can be dangerous, fertility is not always assured, breasts and uteri are vulnerable to the growth of tumors and fibroids, the body is difficult to proof against the aches and pains of aging (Kaufert 1998 p287-288).

In addition, much feminist research and activism has been critical to hard-fought, ongoing struggles to ensure women have access to safe contraceptive and termination methods. Acknowledging embryonic/foetal entities as ‘life’, and therefore subjects to be grieved and mourned, has therefore been thought to undermine these efforts (Layne 1999, 2003a, 2003b). In relation to biomedicine, feminist explorations have highlighted how women as whole body-

persons with agency have largely been displaced by the centring of other subjects, including those of the foetus and the couple (Spallone 1989).

However, Michaels and Morgan (1999) and Ludlow (2008) argue that a feminist and women-centred account of reproduction *must* engage with the multitude of meanings that women themselves attribute to their pregnancies, embryos and foetuses. Although attempts “[t]o recuperate the fetus in feminist terms necessarily forces us into dangerous territory”, it is an important endeavour (Michaels and Morgan 1999 p2; Ludlow 2008). To this end, Morgan’s (1996) ‘foetal relationality’ and Layne’s (2003a) model of foetal subjecthood, concerned with socially constructed rather than biologically or universally given identities, can alleviate some reproductive political tensions. These frameworks recognise that “who or what is called “person” is [...] made possible by as well as produced and sustained in and through social relations” (Hartouni 1999 p300); hence some embryos and foetuses are grieved whilst others are not. The adoption of a subject constructionist model (Layne 2003a) enables recognition of termination without moral insistence extrapolating embryo/foetus to the equivalent of a baby, child or person whilst respecting that some individuals do imbue (some of) their pregnancies with subjecthood. Resonating with Franklin (1991) and Morgan (1996), this reinstates the centrality of the ‘social’ in the production of foetal personhood, crucially resisting a move to ascribe legal personhood and the use of biological development markers in theoretical viability.

For Addelson (1999 p32), Morgan’s (1996) ‘foetal relationality’, by emphasising relationships in the production of embryonic and foetal identities, “represents a theoretical effort to seize the public problems back from biomedical professionals and old-fashioned believers in essential characteristics of individuals”. Distinguishing between social- and biological- life (Hallam *et al* 1999), these approaches permit recognition that *some* persons—including those who may eventually terminate for elective or medical reasons—do imbue their ova, embryos and foetuses with subjecthood and that, when ‘unhappy endings’ (Layne 2003b) disrupt a related ideal or anticipated future, they may grieve, mourn and memorialise these. As noted, the term *loss* is amenable to different understandings and receptive to a variety of lived experiences: a pregnancy loss may not be seen as a loss of a person or an otherwise life, but as the material

loss without assuming or requiring any particular form of emotional, psychological nor moral consequence.

The distinction between those embryos/foetuses which are not grieved and those which are does not neatly map onto a differentiation between termination and other pregnancy losses like miscarriage. My research was open to participation by those primarily or additionally with termination experiences. Terminations are not necessarily instances of freely, autonomously chosen endings to pregnancies even if labelled 'elective'. For instance, terminations can arise out of the use of prenatal medical diagnostic tools with detected foetal anomalies (Stanworth 1987; Sandelowski and Jones 1996; Ginsburg and Rapp 1999; Woliver 2002; Sandelowski and Barroso 2005). The language of 'choice' is troublesome in such contexts, whereby individual women are left with traumatic decisions whilst "we as a society are absolved of collective responsibility to better the lives of different children" (Woliver 2002 p30; also: Lock 1998; Saxton 1998; Sandelowski and Barroso 2005). As Gemma (pseudonym) said, regarding foetal anomalies detected at a routine ultrasound, "I felt like either way we would be playing god – an operation to keep a baby that would otherwise die alive, or a termination". Solinger (1998) highlights that there can also be significant tensions between the language of 'rights' and 'choice': presuppositions that one has 'choices' can mask *de facto* denial of termination access and resources. 'Choice' is a rhetoric familiar within consumerist frameworks of empowerment, implying unbridled, unrestrained options which often entail limitations in practice regarding finances/poverty, interpersonal relationships, and discrimination including racism and ageism (Solinger 1998; Hartouni 1999). Thus, 'choice' can be empty, illusionary and disempowering in the reality of power differentials, curtailed options including that regarding social/welfare support and the furthered medicalisation of pregnancy with only limited abilities to ameliorate many foetal defects (Lock 1998; Williams 2006).

I therefore sought to neither conflate all instances of pregnancy loss nor diametrically oppose them as incompatible. Judgements about different pregnancy loss experiences cannot rely on a dichotomous approach which simplifies the complexity of situations to having either full agency or none at all. I advocate resisting a move which unanimously lumps all terminations as merely 'chosen', oppositional to and conflicting with other kinds of pregnancy

losses. Presuppositions about the emotional responses entailed in different forms of pregnancy loss are also challenged: the decision to terminate a pregnancy can be extremely difficult and distressing whilst the response to miscarriage can be of relief and inconvenience (Reagan 2003; Keane 2009). Since agency is a continuum, the category of 'pregnancy loss' simultaneously expands and fragments by foregrounding that there is no singular experience. Recognising the complexity of situations brings into focus the often "unacknowledged ambiguities" (Solinger 1998 p390) of 'choice' and the diverse ways that agency is present in participants' narratives as they make sense of their pregnancy loss experiences in social contexts. Thus, in negotiating the "fraught task of a feminist articulation of the impact of pregnancy loss" (Kevin 2011 p851) in the context of reproductive debates, Layne's (2003a) and Morgan's (1996) theoretical frameworks are vital. My interest in the multiple circumstances, contexts and responses regarding pregnancy loss experiences (Moulder 1994) has also been influenced broadly by engagements with 'difference' in social and cultural geography (McDowell 1995; Sibley 1995; Mitchell 2000; Murdoch 2006); I now turn to discuss further the ways in which I situate my research within the wider discipline.

Geography and the Marginalisation of Pregnancy Loss

Geography—as a way of thinking with attendance to space, place, location, relations and boundaries—has produced little scholarship on the topic of pregnancy loss *experiences*. Geographical work has, however, highlighted the significance of global disparities regarding reproduction 'events', as shown by Dorling *et al* (2010) in proportional maps based on statistical data of: maternal mortality (defined as death during pregnancy and up to six weeks after giving birth), stillbirth (taken as foetuses born dead >28 weeks gestation) and early neonatal mortality (understood as baby deaths within one week of birth).¹ However, engagements with the *experiences* of pregnancy loss in the global context remains limited, with van der Sijpt's (2010) anthropology work regarding Cameroon being an exception. Van der Sijpt (2010) argues that the

¹ These cartographic representations highlight global disparity, as reiterated in a 2011 series of papers on stillbirth in the medical journal *The Lancet*. Bhutta *et al* (2011), for example, argue that stillbirth has been invisible in policies and programmes worldwide despite 98% of stillbirths occurring in low- and middle- income countries (see also Frøen *et al* 2011).

predominant omission pertains to reductionist discourses regarding global health so that studies on fertility in Africa often overshadow pregnancy losses with other pregnancy-related issues or adopt a medicalised approach rather than situating these events within women's everyday social lives. Whilst the global context is certainly important for further and sustained consideration by geographers, including of women's lived experiences in the global South as van der Sijpt (2010) demonstrates, the disciplinary attunements of geography also highlight a range of other spatial contexts and approaches for further research including on pregnancy losses in contemporary Western societies.

'Experience' denotes the processes of 'living out' and 'living through' existence, and is comprised of multiple temporal, spatial, emotional, material, bodily, sensorial, discursive and social dimensions. My approach as a social geographer to pregnancy loss therefore entails attending to a variety of the 'spaces and places' involved in these experiences. The social dynamics of some locations have been part of previous pregnancy loss scholarship within, for example, anthropology and sociology. For instance, Bleyen (2010) considers memorial objects within the homes of parents who have experienced stillbirth in Belgium and Layne (2003a) discusses US face-to-face support groups as well as their circulated newsletters. In the UK context, Woodthorpe (2012) explores the setting of baby gardens/cemeteries and Letherby (1999) remarks on the medical encounters of some of her participants put on general gynaecology or post-natal wards during miscarriage. However, I suggest that a geographical approach can further articulate the ways in which space matters to pregnancy loss experiences and expand the array of locations which can be understood in these terms. This includes attendance to 'the body', described by Rich (1986 p212) as the "geography closest in". Doing so can elicit some of the complexities of pregnancy loss experiences, with better understanding supporting better care, and further advance various sub-disciplines within geography.

One reason behind the seeming overlooking of pregnancy loss experiences within geography likely pertains to historically dominant hierarchies of patriarchal power relations at the forefront of knowledge production. With implications for the 'who' and 'what' of scholarship, women have been historically excluded both as producers and subjects of geographical knowledge (Rose 1993). Pregnancy and therefore pregnancy loss may have been

largely overlooked or dismissed as plausible areas of geographical study owing to the ways in which these are inseparable from women's physiological and psychological lived experiences. Drawing on the work of Rothman (1989), Woliver (2002 p123) highlights how "pregnancy and motherhood are continuously described from a male perspective":

[t]o say that women first hold their babies after they are born is to say that the nine-month experience of pregnancy was nothing. One reason pregnancy does not "count" here is because men cannot experience it. As an exclusively female experience, pregnancy is often discounted and belittled in powerful men's discussions about babies.

This may help explain why 'male-stream' geographical scholarship has had little interest in the spatial nature of pregnancy and pregnancy loss experiences.

However, supported by wider scholarly turns to 'bodies' (Longhurst 1997a, 2001, 2005), 'emotions' (Davidson and Milligan 2004; Bondi *et al* 2005) and 'touch' (Paterson *et al* 2012) in recent years, vibrant feminist geographies have emerged (McDowell 1992; Rose 1993; Blunt and Rose 1994; Hanson 1999; Blunt and Wills 2000; Staeheli and Martin 2000; Bondi and Davidson 2003). Subsequently, feminist geographies have brought many important issues into focus, including in relation to health, reproduction and maternity. This involves topics such as: chronic illness (Moss and Dyck 2002; Crooks 2006); agoraphobia (Davidson 2000) and links with pregnancy (Davidson 2001); 'sized' bodies and shopping (Colls 2006); family photographs (Rose 2010); the public scrutiny of pregnant bodies and emotions (Longhurst 1997b, 1999); maternity clothes (Gregson and Beale 2004; Longhurst 2008); online pregnancy/mothering websites (Madge and O'Connor 2002, 2005); breastfeeding (Boyer and Boswell-Penc 2010; Boyer 2011); midwifery (Fannin 2007); childbirth (Sharpe 1999; Longhurst 2009); cord-blood banking (Fannin 2011); placentas (Colls and Fannin 2013); and hysterectomies (Collis 2005), as well as furthering feminist methodologies (Rose 1997; Sharp 2005) and pedagogies (Dowler 2002; Davidson *et al* 2009). These works, attending to women's experiences, are important for the ways in which they "spill, soil and mess up, clean, hard, masculinist geography" (Longhurst 2001 p25).

My research also seeks to contribute to the developing sub-discipline of the geographies of death and dying (Hartig and Dunn 1998; Kong 1999; Teo 1999; Yeoh 1999; Maddrell 2009a, 2009b, 2010, 2013; McLoughlin 2010; Hockey *et al* 2010; Maddrell and Sidaway 2010). Yet, if culturally pervasive normative notions of death, bereavement and grief prevail over the understandings of those intimately involved, pregnancy losses are unlikely to be recognised as bereavements (including even those medically/legally regarded as such). Qualifying life and death biologically and post-partum neglects the myriad ways social life comes to exist as “family lives are dreamed into being” (Hockey and Draper 2005 p54) via thought, speech, material accumulations and practices (Layne 2000). I am in agreement with Casper (1999 p110) that “[f]etal ontology, like other social categories, is produced within social interactions rather than biologically or naturally given”. I argue that dismissive attitudes towards the potential significance of pregnancy losses arise from a failure to take into account the distinction between biological- and social- life and death (Hallam *et al* 1999). Constituting ‘ambiguous losses’ (Boss 1999; Cacciatore *et al* 2008), pregnancy losses are often rendered forms of ‘disenfranchised grief’ (Doka 2002; Rowlands and Lee 2010), frequently met with ‘silence’ and/or trivialisation from social others. Those who have pregnancy losses thus may encounter various kinds of social and medical silencing and insensitivity towards their experiences with their emotions (like grief) and responses (like mourning and memorialisation) potentially dismissed as pathological, unhealthy and hysterical, with the latter drawing on the longstanding statement pertaining to women’s reproductive bodies (Shohat 1998).

Despite relatively little work in geography on pregnancy loss experiences, the discipline does nonetheless afford relevant theoretical resources. Subsequently, I draw from geographical work on themes of feminism, bodies, emotions, material culture, death and dying, and online activities to articulate the spatio-temporalities of research participants’ pregnancy loss experiences. In bringing together multiple literatures, I develop a response to Layne’s (2003a p249) comments that “[i]t is high time we recognize pregnancy loss and offer our support”. In articulating “a woman-centered discourse of pregnancy loss” (Layne 2003a p239), I will foreground bodies as physical, emotional, social spaces, as well as the spaces they occupy, to consider dimensions which are seemingly absent or only partially addressed in much existing pregnancy loss

literatures. I seek to not only demonstrate the presence of bodies in pregnancy losses, which seems relatively obvious, but to address the ways vital interconnections between bodily materiality and emotions matter. Murphy and Philpin (2010) suggest that early miscarriages are (or can be) about bereavement but also physiological manifestations, such as bleeding, which are somewhat paradoxically neglected in nursing practice (Murphy and Philpin 2012). Similarly, I argue that, in an effort to legitimise pregnancy loss grief, much focus in the academic literature has been on the ways cognitive efforts are made to (re)create and (re)confer subjecthood/personhood onto lost/deceased embryos, fetuses and neonates. Subsequently, the material bodies of pregnancy loss 'babies' have prominently featured; for example, Layne's (2000) work considers 'baby things', like clothes and toys, in addition to photographs and scan images as constituting 'evidence' of past bodily existence.

In effect, I find the focus on embryonic/foetal baby bodies to have eclipsed the bodies of pregnancy-losing women themselves. I am not claiming that women's pregnancy-losing bodies are altogether absent from the previous literature, indeed they are always implicitly present, but rather that there is more to consider. Equally in my research, I do not discard the significance of embryonic and foetal subjects but agree with Michaels and Morgan (1999 p2) and Ludlow (2008) that feminist scholars must "recuperate" and take seriously 'the foetus' by attending to the social meanings attached to these by different women (and men). My interest in foregrounding embodied experiences of pregnancy loss is intended as a feminist endeavour which recognises that there have been some important changes since the conduct of the 1990s strand of feminist research as noted by Davidson (2007). Such bodily experiences are not asocial or temporally fixed and there are a number of contemporary factors with implications for pregnancy losses. These include: the routinisation and diversification of medical technologies involved in conceiving, diagnosing and managing pregnancy and pregnancy losses such as urine tests, ultrasonography and prenatal testing (Chapter 3); the further normalised construction of foetal personhood including with more involvement encouraged for persons such as partners (Chapter 4); particular understandings of encountering deceased bodies in grief/funerary practice (Chapter 5); the proliferation of online technologies permitting easy and sustained participation in computer-mediated support groups (Chapter 6); trends of tattooing as a popular body modification

practice generally and in relation to memorialisation specifically (Chapter 7); and an age of ‘memorial mania’ (Doss 2010) involving a plethora, and extensive deployment, of other forms of memorial activities (Chapter 8).

Research Agenda

In the absence of providing specific research questions, in this short section I will outline how I arrived at conducting research on pregnancy loss in order to highlight some of the conceptual and empirical elements which feature in this thesis. My relationship to the research topics can be characterised as iterative, as interests preceding the doctorate coalesced and connected with new/other themes, meaning that the process involved looping back and forth as ideas intersected and altered the directionality of thought. For instance, during my MA degree, I developed an interest in body spaces and body modifications—underpinned more broadly by concern with feminist research (geographical and otherwise)—in relation to traumatic experiences like bereavements. This included, for example, researching about participants’ narratives of memorial tattoos and the usage of material objects previously owned by the now-deceased – two themes which also feature in this doctorate work. My commitment to feminist theory and the value of practices of meaning-making and expression regarding experiences, especially those which are troubling or traumatic, remain dominant presences in this doctorate research on spaces of pregnancy losses.

It was an interest in memorial practices, and particularly those concerning photographs, through which I became aware of memorial websites for stillborn babies. The spur to further research these developed as I became aware of some seemingly widely-held reactions regarding these sites and especially to the photographs of stillborn children: of shock, horror and repulsion alongside trivialisation. These responses became evident as I searched online for further information, coming across numerous blogs and comments characterised by hostility, in addition to informal conversations with peers who had enquired about the changed direction of my research project away from the circulation of images of the now-deceased, pre- and post- mortem, in the news media. The notion that these sites were somehow inappropriate and offensive to others, for marking grief and enacting mourning for stillborn children, both shocked and surprised me initially. As I reflected on this, at the base of responses of rejection there seemed to be a fundamental misunderstanding. For

me, the memorial websites did not feature ‘gore’, even if/when depicted bodies were not always aesthetically ‘contained’ and ‘sanitised’ (a recognition of the fleshy and fluid experience of bodies being at the core of many underpinning feminist critiques), but rather were emotionally powerful expressions of love and loss. Broadening out to think about other forms of pregnancy loss, my doctorate research sought to elaborate understanding about these experiences as more than medical events in order to rectify the seeming misconceptions I observed, and which Layne (2003a) demonstrates to be socially prevalent, to make an intervention through offering recognition and opportunities to talk.

Layout of the Thesis

The thesis is comprised of nine chapters in total, including six empirical chapters into which the relevant literatures are woven. Chapter 2 will outline my methodology, emphasising the centrality of feminist, sensitive, and online/multi-communication research practices. All the empirical chapters in the thesis attend to different elements of spatial contexts in thinking about the body as a space, or series of spaces, and as occupying/moving through other kinds of spaces. Chapter 3 will consider internal/interior body spaces in relation to human chorionic gonadotropin (hCG) tests, ultrasonography and quickening. Encounters with medical interventions, technologies and staff will be foregrounded in relation to experiences ‘prior’ as well as ‘during’ and ‘after’ the occurrence of pregnancy losses. Chapter 4 elaborates on themes of grief legitimacy, recognising that pregnancy losses entail wider social and interpersonal contexts including partners, family members and work colleagues. Chapter 5 will then attend to bodily experiences of encounters with pregnancy loss fluids/flows such as uterine bleeding, lactation, tears and the accompanying spaces such as toilets. Although such bodily experiences are heavily connoted as ‘private’, they are also discussed in relatively public domains: Chapter 6 will reflect on online pregnancy loss activities as involving (reconstituted) bodies and social hierarchies of belonging. Following this, bodily experience will again feature prominently in Chapter 7 in relation to surfaces of skins, contours and bumps which participate in pregnancy loss narratives. This will include discussion of forms of modifications to external skin topographies and bodily contours such as stretch-marks, maternity clothes, and memorial tattoos and jewellery. Chapter 8 will then build further on the theme of mourning and

memorialising pregnancy losses in relation to themes of ‘absence’, ‘presence’ and ‘continuing bonds’. Finally, the concluding chapter will draw together key themes of the research and their implications in terms of contributions to various sub-disciplines and relevance for future research.

Methodology

Introduction

The processes of ‘doing’ research and the data produced are, far from being separate entities, “reflexively interdependent and interconnected” (Letherby 2003; Mauther and Doucet 2003 p414). With this in mind, this chapter will outline the methodological underpinnings of my project, reflecting on: participant recruitment; ethics and sensitivity; qualitative interview practice by face-to-face, telephone, email and Skype; positionality; reflexivity and power relations, including around ‘voice’. Subsequently, it will blend pragmatic details about the research and conceptual considerations, connecting particular issues with potentially significant (practical, ethical, theoretical) implications for the kinds of ‘data’ (narratives) produced. In seeking fit between the topic and research methods, three sets of non-mutually exclusive literatures were particularly pertinent for me: those attending to feminist, ‘sensitive’ and online/multi-communication research contexts. After providing a brief overview of some key points regarding the research, I will discuss each of the three key sets of academic literatures in turn. I will then bring together respective insights to consider my research focus on pregnancy loss entailing potentially intimate or difficult conversations about bodies and emotions. Within this, I will reflect on some of the ways ethical tensions were approached in practice with constant vigilance and readiness to respond, yet sometimes without ‘resolution’ as such. Before closing the Methodology chapter and moving onto the first empirical chapter, I will outline the approach taken to research data analysis.

My research mobilised around the term ‘pregnancy loss’, stemming from an effort to acknowledge a variety of physiological circumstances, to allow participants to identify with (or challenge) such a label at their discretion without imposing implicit judgements about which losses ‘matter’. Recruitment was enabled through ‘Call for Participants’ posts which I placed on various pregnancy loss support web-forums and social network sites. Though recruitment via online opened participation to many locations, most participants were based in the UK, which provided an opportunity to, for example, address the “particular dearth of insight” into UK pregnancy loss memorialising practices (Woodthorpe 2012 p144). Multiple qualitative interviews—in face-to-face, telephone, Skype and email formats—were

conducted with each self-selecting participant when possible, sometimes extending over a period of many months to suit participants' preferences and schedules. In total, I spoke to 24 persons: 21 women discussing primarily their own pregnancy losses, one male partner and two siblings (one male, one female). All participants are attributed a consistent pseudonym name and, related to feminist research efforts for participants' voices' to be 'heard', I quote from interviews often and sometimes extensively. As a result, the circumstances of some participants will accumulatively become familiar to the reader and short participant vignettes are also provided to consult in Appendix 1 (pp255-265). To minimise the risks of participants being identifiable, I have also removed reference to the names of social others (their family, children, friends, work colleagues), specific dates (of births/deaths), place names (cities, towns, hospitals) and any particularly rare medical details if known to be as such.²

Feminist Research Practice

A historical overlooking of women's experiences, especially regarding reproduction, is noted throughout academia, including in the discipline of geography (Rose 1993). In response, feminist research is fundamentally interested in the "reclaiming and validation of women's experience" since these, "not fitting the male model, [...] [are often] trivialized, denied or distorted; our perceptions are systematically pathologized; we are crazy women, imagining things, making a fuss about nothing" (Kitzinger and Wilkinson 1997 p566). I consider pregnancy loss a topic particularly amenable to feminist exploration, as does Layne (2003a p239) who calls for the creation of "a woman-centered discourse of pregnancy loss". However, there are aforementioned tensions between the topic of pregnancy loss and feminist research, such as around termination and reproductive justice (Layne 2003a, 2003b; Michaels and Morgan 1999). Kitzinger and Wilkinson (1997) highlight that feminist researchers can face dilemmas when confronted with participants' views or experiences which differ from their own theoretical and political positions. Since feminist researchers "do *not* simply 'validate' every women's experience",

² Participants were also invited to inform me if they had disclosed any information which they, at the time or later, felt uncomfortable about or which might risk their anonymity so that I could remove or alter these in the write-up. Despite these efforts, as the informed consent document reiterated, it may still be possible that others could identify them.

the authors encourage reflection on “[h]ow are we to address the experience of such women, which does not fit our (feminist) theoretical frameworks?” (Kitzinger and Wilkinson 1997 p568 italics in original, p567). I subsequently sought to adopt “a politics of ambivalence [which] is not about ‘sitting on the fence’, but about creating spaces in which tensions, contradictions and paradoxes can be negotiated fruitfully and dynamically” (Bondi 2004 p5).

Interview Methodologies in Feminist Research

A method cannot be inherently feminist, though my deployment of semi-structured interviews is part of a commitment to ‘feminist research practice’ (Letherby 2003, Sharp 2005). The research was intended as part of wider feminist endeavours to ‘give voice’ to women’s experiences and, specifically, to contribute to ‘breaking the silence’ around pregnancy loss as identified by Layne (2003a, 2003b). Whilst other methods are amenable to feminist aims (Kwan 2002 on feminist GIS; Sharp 2005), qualitative interviews have often been used since these enable opportunities for participants to speak extensively about their lived experiences. This is a key way in which ‘the personal is political’, a slogan attributed to Hanisch (1970), has been translated into grounded scholarship. In my pregnancy loss research, I used semi-structured, multiple, qualitative interviews, seeking to interview each participant at least twice, in the formats of face-to-face, telephone, email and Skype. The heavy use of quotations from participants in this thesis connects to wider feminist endeavours to convey the voices of participants (Holloway 1989). However, influenced by Kitzinger and Wilkinson (1997 p567), I do not wish to present myself “as no more than amanuensis or conduit for other women’s experiences” but instead acknowledge that I have unavoidably selected and framed in particular ways participants’ experiences and words in the write up of my thesis.

Qualitative interviews are conversational and interactional encounters with complex emotional dynamics (Bondi 2005). This includes: participants’ emotions as they reflect on, and narrate, their remembered experiences (hopes and fears); my own emotional responses; and the interaction of both of these with bodily gestures, verbal/textual responses and interview atmospheres (Bondi 2005). Attending to the emotional dynamics in research relationships can highlight aspects requiring alteration or rethinking to foster more sensitive, careful and supportive interview interactions (Bondi 2005). In addition,

recognising—rather than negating—emotions within research settings can constitute an important set of interpretive resources, bearing upon analysis and understanding since “our feeling states and our thinking are closely intertwined” (Bondi 2005 p236). In the context of my research, a recognition that “emotions are integral to research relationships” (Bondi 2005 p232) is linked to the overtly feminist framework adopted. This pertains to the ways in which emotions have historically been dichotomised and de-valued in gendered ways in contrast to ‘rationality’, ‘objectivity’ and ‘reason’ (Williams 2001). Explaining dualisms as “the belief that there are two mutually exclusive types of “thing,” physical and mental, body and mind, that compose the universe in general and subjectivity in particular”, Grosz (1994) considers the ways feminists have worked beyond the legacies of phallogentric, binarised thought. Valuing emotions as knowledges can therefore constitute a challenge to the masculine privileging of disembodied ‘rationality’ which has tended to represent emotions as a feminine, distracting and deceptive ‘other’ (Williams 2001).

Positionality and Pregnancy Loss

Franklin *et al* (1991) argue that a focus on knowledge and power relations in academia can enable consideration of the links between personal experience and theoretical approaches/questions. Autobiography is now more overtly incorporated in social sciences and humanities scholarship than previously, with recognition that personal experiences can be rich interpretive resources. Within this, emotions are foregrounded in the production of poetic and ‘heartful’ autoethnographies (Ellis 1999). Autobiographical reflections have also featured prominently in some of the qualitative research on miscarriages and stillbirths (Cotterill and Letherby 1993; Layne 2000, 2003a, 2003b; Reagan 2003; Davidson 2007, 2011; Murphy 2009; Forhan 2010), terminations (Ellis and Bochner 1992), and both voluntary and involuntary non-motherhood (Letherby and Williams 1999).³ The ‘confessional turn’ in scholarship has extended the feminist project in highlighting connections between individual and social experience, that ‘the personal is political’; however, it is not without criticism (Swan 2008). As cautioned by Swan (2008, drawing on Boud and

³ In addition, autobiography features in some research generally on reproductive experiences, such as Ivry (2010) on differing cultural approaches towards prenatal testing in Israel and Japan in her experience of pregnancy.

Walker 1998), it would be an error to consider personal experience ‘raw material’ when our articulations of these are always already culturally framed through particular interpretations and analytical categories. This comment resonates with my ambivalence regarding the autobiographical trends which can risk implying that ‘personal experience’ is a necessary and/or privileged position in order to legitimately research on, for example, pregnancy loss.⁴

My decision to not disclose either way whether I myself have experience of pregnancy loss in this thesis is, of course, not a simple one to have made. In doing so, I wished to disrupt what I felt to be a pressure or coercive imperative to ‘self-tell’ (Swan 2008, drawing on Skeggs 2002) emerging from some of the existing literature and from queries in response to, for example, my academic presentations. By no means do I wish to imply disapproval of other researchers who do disclose their personal experiences of pregnancy loss as a central justification or resource in their research, but I am stating that I myself did not wish to or consider it vital for this to be the case in my own work. This may seem to go against the grain in the sense that much feminist research practice has emphasised the importance of reciprocal ‘openness’ with participants and the ways in which, by sharing information about themselves, researchers can foster better rapport (Oakley 1981). Thus feminist research has fronted a significant encouragement to consider ethics and power relations in order to protect participants, but attempts to do so can also be problematic. Irwin (2006 p170) comments, “subjectivity is not more or less exploitative than objectivity [...] If researchers and research participants enact inequalities when they are intimate, intimacy can be even more damaging and problematic than objectivity”. Subsequently, that the encouragement to ‘self-tell’, as a form of interactional

⁴ The notion that one must have experience of something in order to understand it underpins self-help movements. However, in Chapter 6, I argue that this is a potentially unhelpful notion, risking the valorisation of ‘shared’ experiences regardless of the differences actually entailed and the exclusions. My hesitancy towards self-disclosure, therefore, derives not from viewing it as ‘anti’ or inappropriate to academia but rather owing to the ways in which it can become a demand with some problematic consequences.

intimacy, can unintentionally exert expectations on or ‘set the parameters’ of discussion for participants’ talk was one reason for my non-disclosure.⁵

There is something of a tension between protecting participants’ privacy and the vulnerability of the ‘exposed’ self-telling researcher since “[t]o undertake such [autobiographical] projects involves [the researcher] taking exactly the kind of personal risks and exposure from which feminist ethics seek to protect research participants” (Inckle 2005 p243). As with this research, participants are attributed pseudonyms to reduce identification by others; yet such a protective endeavor is not afforded to the author whose name is necessarily evident. There may be particular assumptions made about researchers based on their academic interests but this is not the same as self-disclosure or doing so in all contexts/settings of one’s life (Valentine 1998). As it transpired, perceiving me to be ‘young’ and not describing myself as a mother, some participants assumed that I would not have personal experience of pregnancy loss either.⁶ Some participants adopted relatively protective stances towards me in offering advice, demonstrating how my young, female body “shaped how people understood and responded to me” (Ellingson 2006 p306). For instance, regarding the invasiveness of vaginal examinations in relation to her miscarriages, Caroline made a comparison to smear tests and brought me/my body, history and anticipated future of cervical checks to the fore: “you can imagine and that is [very invasive], well, I’m sure you’ve been to see it [smear test] or if you haven’t, you SHOULD because you’re a young woman”. My reproductive future again emerged in a subsequent interview as Caroline implored: “that’s my advice to you if you ever have children, don’t be rushing down the shop to buy these [HCG urine test] kits, WAIT”.

⁵ I did not mention whether or not I have personal experience during recruitment, including in conversations with the online group gatekeepers, nor with participants *unless* I was directly asked and/or it was deemed significant in that particular context for the participant to know.

⁶ Normative assumptions about who has, or ‘should’ have, children probably also featured. As a ‘young’ female, it seemed largely assumed that my pregnancy/child-bearing experiences were forthcoming rather than having a history and/or current. Linked to this, there were moments when participants drew on or challenged particular judgements/assumptions regarding ‘teenage pregnancy’ as fraught with, for example, ageism (‘too young’) and classism (socio-economic poverty/deprivation). For further critiques, see Pillow (2006) on the bodies of pregnant students in schools and Ladd-Taylor and Unmansky (1998) on mothers labelled ‘bad’.

(Non)Disclosure and Knowledge Produced

In effect, I enacted a form of management largely through inaction regarding self-telling which, in an academic field where disclosure is somewhat a norm, is a deliberate action. However, since “the location and perspective of the researcher is both inseparable from, and integral to, the knowledge produced” (Inckle 2005 p233), there were implications nonetheless. Reflecting on this dimension of my positionality, I recognise that my non-disclosure decision—with the simultaneous operation of assumptions seemingly being made in the absence of disclosure either way—will not have been a neutral presence, as the aforementioned examples from Caroline highlight. However, as is the way with all attempts at reflexivity, determining exactly what the outcomes were—in different situations and in different ways with/for participants—of how I was positionally perceived is near-impossible (Rose 1997). Crucially though, I would not necessarily agree that a sense of reciprocity in sharing experiences of, for instance, pregnancy loss inevitably means that participants disclose more; what is disclosed, however, may well be different.

Contrary to concerns that, without reciprocal self-disclosure of shared experiences, participants would not ‘open up’ about their experiences, being perceived as reproductively inexperienced meant that participants sometimes gave incredibly detailed accounts. Had they perceived me as having had the ‘same’ experiences as theirs such as of prenatal tests in pregnancy, it may otherwise have been assumed that my familiarity did not necessitate their elaboration. Although I have suggested that participants assumed that I did not have personal experience of pregnancy or, hence, pregnancy loss, tentative uncertainty was present on some occasions. Rosie, for example, commented “I don’t know if you know the pain of ectopic” before then following this up with quite a detailed description of her felt sensations regarding medical investigation in recognition that I may well not have experienced this physical scenario:

but it’s sort of up in your shoulder blades but erm... because they pump your stomach full of gas to be able to get a clear shot at your fallopian tubes as you then sit up and recover, all that also migrates up your body cavity and into your shoulders, so it was ‘I’m still in pain!’

As the first participant spoken to with experience of fertility treatments, Rosie was also valuable—being very thorough in her explanations and generous in her clarifications—in helping me grasp a range of medical terminologies and treatments (including the UK brand names of pharmaceuticals such as Clomid). Although I was sometimes positioned as academically knowledgeable about, for example, pregnancy loss grief, the fact I was largely deemed to be an ‘outsider’ without personal experience of pregnancy loss could yield very rich ‘data’. Some of these narratives may not have been articulated in this way had participants deemed me to be an ‘insider’ with the ‘same’ or similar experiences as theirs.

Sensitive Research

The emotional, embodied nature of pregnancy loss meant that considering sensitivity was crucial to minimise the risks of contributing additional distress and psychological harm. My interest in facilitating ‘sensitivity’ in interactions with others drew upon professional/academic ethical guidelines such as that of the British Sociological Association (BSA), methodological discussions generally (like Lee 1993) and on pertinent topics (such as: Dickson-Swift *et al* 2007 on health research; Adamson and Holloway 2012 on death and bereavement), previous research experiences (with my MA dissertation on bereavement narratives) and volunteering background. Although these literatures do not always have consensus, some important considerations were located. Professional ethical guidelines like that of the BSA (2002) state that social research ought not to cause physical or psychological harm to participants and that, accordingly, the project design and conduct ought to be tactful, sensitive and prepared with adequate provisions in cases where there are needs for additional support. The notion of protecting participants from harm in a research project premised on a fundamentally distressing topic like pregnancy loss, however, is tricky. Still, to not research pregnancy loss can be understood as partaking in the academic and wider social silencing or self-censoring of these experiences; as Layne (2003a p239) argues, “[i]n retaining a studied silence on pregnancy loss”, (feminist) researchers “have contributed to the shame and isolation that attends these events”. To deem pregnancy loss too sensitive or taboo to talk about, in effect, enables a continuation of the longstanding silencing derived from the notion that it is too ‘insignificant’ to talk about or research.

Risks and Rewards

Faulkner and Tallis (2009), in the context of mental health survivor research, argue that it is important to recognise that distress is not necessarily the equivalent of harm and that we must not unnecessarily jump to conclusions that participant upset is caused by the researcher. Indeed, it seems deeply problematic that, on the advent of the signs/expression of ‘challenging’ emotions such as anger or sadness, a researcher might terminate the interview and thus silence or condemn what may be, as Faulkner and Tallis (2009) note, a valuable cathartic experience for the participant. Researchers need to be simultaneously sensitive to the needs of an interviewee for support during/after a distressing interview but also respect participant needs and autonomy to participate. Corbin and Morse (2003 p341) posit that, with careful management, “risks are often contained and mitigated by the benefits that participants receive by telling their stories”. This pertains to the fact that the conditions of trust and conversational intimacy involved in talking about sensitive topics which threaten to cause harm are also those enabling potential ‘therapeutic’ benefits (Corbin and Morse 2003). Bondi’s (2005 p240) reflections on her research experiences certainly resonate with my own at points throughout the research:

if people freely consent to participate in research interviews, they probably really do want to make use of the opportunity to talk that it affords them! [...] researchers like myself should, surely, respect their capacity to make decisions, which was something I was at risk of forgetting in my preoccupation with my own sense of guilt [...] I did not know better than those I interviewed about the pros and cons of participating in the research, but I was at risk of allowing my feelings of guilt to convince me that ‘really’ the cons must outweigh the pros regardless of what participants said to me.

Subsequently, the researcher should not position themselves as ‘knowing best’ in a paternalistic fashion over that of the participants and it ought to be acknowledged that the benefits of research can be two-way. Adamson and Holloway (2012 p739) encourage recognition that “[p]articipants volunteer because they want something even if this is unconsciously and is only to talk to a sympathetic listener”. Participants reporting beneficial outcomes from revisiting their experiences during research can be found in the perinatal loss (for

example: Kavanaugh and Ayres 1998), as well as other forms of grief/bereavement (for example: Hentz 2002; Dyregrov 2004) and feminist (for example: Finch 1984) literatures. This seemed to be the case for some of my participants also, including for those who had not spoken about their experiences at length with anyone else before partaking in the research.⁷ For example, Penny commented “it[']s been good to talk to [yo]u as well as its good to get it all off[f] my chest and you being interested shows that [I']m not alone and that well what happened to me is important”. This links to discussions about the ways researchers, in the practice and production of their research, can facilitate the unsettling of particular norms held by participants (Sinding and Aronson 2003). In another example, Fiona said:

I'd like to say thanks also, I know you were just conducting your research for your job but just being given the opportunity to talk about my experience has helped me so much and I hope in turn that anything I've mentioned has been able to help you also.

Isabel also found that participation in the research could yield therapeutic benefits: “I found it tremendously helpful speaking to you and I’ve sort of treated it a bit as my therapy, being able to just talk, talk the whole thing through with you”. It was made apparent within the informed consent form that I am not a trained counsellor/therapist (hence this was *not* actually therapy) but nonetheless the opportunity to talk could be therapeutic and, as Adamson and Holloway (2012) advise, I was able to provide information on sources of help (professional counselling services) when requested or deemed suitable.

Enacting Sensitivity

⁷ I am aware that this may not have been the case for all participants or at all times. In addition, Kavanaugh and Ayres (1998) comment that it is not necessarily possible to assess participant experiences of the research based on words spoken in an interview alone. Therefore, it is important to also keep a record of participant behaviour throughout the research which includes details such as cancelled interviews and non-returned contact (Kavanaugh and Ayres 1998). For instance, contact from Carla ended without explanation when she did not attend our (rescheduled) second interview and, although I contacted her after the missed interview, I have not heard from Carla since. This leaves me to speculate that the ceased contact may pertain to her finding it too distressing to revisit the experiences and/or embarrassment/awkwardness regarding the missed interview.

It is vital not to designate some research topics as ‘out-of-bounds’ but, providing that there are informed and consenting individuals willing to take part, to concentrate on enacting sensitive encounters in research design and practice. Adamson and Holloway (2012 p739) suggest that “[t]he researcher can provide support, often in silence, just by being present”. In contrast to many other social encounters, a research interview about pregnancy loss constitutes a setting with another (the researcher) in which talking about these experiences is *not* a transgression. Whilst respectful that participants may wish to pause the interview, and were free to suspend it or their future participation at any point, I sought not to shy away from emotionally intense discussions and displays. As Kavanaugh and Ayres (1998 p94) comment, “crying is not always the cue for the interviewer to intervene”. I hoped that my ‘being with’ participants could offer some comfort in the sense of companionship with a listener quietly present. Inevitably, participants manage their emotional displays differently and I sought to accommodate these preferences during the interviews. In addition to being able to talk at length about their pregnancy losses, some participants may have found it beneficial to be expressly emotional. This can contrast with existing (familial) relations, as highlighted in the following excerpt with Anne speaking about her grief following a stillbirth and her mother’s avoidance of this:

if she says anything and I start to cry, she can’t handle it and she goes ‘arrrr I’m sorry, I’m sorry, I won’t talk about it’ and give[s] me a hug or something and all I want to do is just to be able to express myself and sometimes that means crying and that’s alright [...] you know, it’s fine to cry, I don’t quite understand where this thing comes from about it not being okay to cry, it’s perfectly normal to cry, you know, your baby’s dead, it’s {laughs} it would not be very normal to not cry.

Hence, part of the sensitive research methodology I employed entailed recognising that distress about an experience does not necessarily require removal or sanitisation from the interview but sometimes its very recognition and, indeed, validation.

Recruiting Participants

The practical and ethical difficulties of researching sensitive topics include access to and recruitment of participants, owing to their awareness of potential emotional risks and varying willingness to talk about difficult experiences (Adamson and Holloway 2012). Constituting the first interaction with most potential research participants, the process of recruitment was one in which I wished to convey sensitivity. I placed my 'Call for Participants' (CFP) on a number of online pregnancy loss support forums/threads and social network groups after negotiating permission to do so with the site owners/admins. As many researchers caution (Valentine 2005), my own encounters with 'gatekeepers' entailed long and sometimes difficult processes in seeking to negotiate permission to post. This included unanswered or delayed replies to my emails and sometimes ambivalent or hostile responses. Whilst anyone with Internet access could register and, often without a delay in awaiting approval, then be able to post on the online groups, I felt it was important that I sought permission from the website/forum owners or moderators before posting about my research. This pertains not only to general (n)etiquette and practical benefits that gatekeepers can potentially facilitate, such as validating the legitimacy of the research, but also shared recognition that pregnancy loss research carries risks and is likely to involve emotionally vulnerable persons (Chen *et al* 2004).⁸

The online posting of my CFP meant that recruitment entailed individuals' self-selection, resonating with the earlier comments by Bondi (2005) about the autonomy to balance 'pros and cons'. Of course, this did not preclude later revision of partaking in the research and the option to end participation at any point, for any reason was openly reiterated. In addition to the online support groups in which I posted my CFP, it was also independently forwarded on and re-posted. Thus an element of Internet-based snowballing also occurred which, as will be discussed in Chapter 6, enabled participation by

⁸ As it manifested, I did not develop any noteworthy relationships with 'gatekeeper' owners/moderators. This may have been due to my writing style in communication, being a young PhD researcher or that such research is a lesser priority over the everyday work put into the groups. The explicitly qualitative and open nature of the research, since I did not outline a particular question or challenge to tackle, may have been another factor in the seeming lack of interest. Later in the research, with interviews ongoing, I again contacted some group owners to enquire about any topics that they would be keen to receive feedback on and to shape the research agenda, however, responses received again ranged from lukewarm to indifferent.

some individuals who did not otherwise use these online support groups. The self-selection recruitment of participants is, therefore, part of a commitment to sensitive methodologies and a prioritisation of a research sample able to provide depth of understanding as illustrative rather than representative (Valentine 2005). Additionally, potential participants were provided with flexibility in terms of, for example, communication methods such as face-to-face, telephone and email interviews; for an overview, see Appendix 2 (p266).

Online and Multi-communication Research

In addition to interest in how the Internet features within participants' experiences of pregnancy loss (elaborated in Chapter 6), the research was enabled methodologically by the Internet.⁹ A specific research email account was set up to manage exchanges with potential participants. When individuals contacted me about participating in the research, I emailed back and thanked them for their interest, reiterated the CFP and attached a four-page informed consent form which, if preferable, I would print off and post to them with a stamped return envelope. Aware of the multiple ethical difficulties and sensitivities entailed in the research, the informed consent form covered numerous aspects such as the use of pseudonyms and rights to withdraw from the research. In addition, this document highlighted communication flexibility to provide participants with various degrees of suitability to their (practical and emotional) circumstances. For instance, email interviews offer asynchronous communication, allowing the participant to write in sections over a period of time and accommodating to interruptions, preferred pace and time away for thinking/rewriting (Ayling and Mewse 2009; Hamilton and Bowers 2006; Beck 2005; Brownlow and O'Dell 2002). As such, email interview exchanges could fit around other priorities such as work and/or childcare as well as enable the participant to determine their preferred pace. This is especially important to support 'self-care' given the possible emotional distress that may arise from

⁹ In addition to email interviews, email contact was helpful for: setting up face-to-face, telephone and Skype interviews; exchanging follow-up comments (such as after interviews), updates and transcripts; and receiving documents (including participants' creative writing) and images (of memorial objects in the home, but also, from some participants who had been pregnant during the research, new-born arrival notifications/photographs). Some participants emailed me web links to their memorial pages, poetry/creative writing accounts and blogs about pregnancy loss, as well as online shops selling 'memorial' items they owned.

recollecting the experiences and I sought to implement flexibility around the participants' preferences and priorities with all modes of communication. For example, as some participants had young children and/or daytime jobs, telephone interviews were sometimes conducted relatively late in the evenings.

Different Modes of Communication

Participants' engagements in my research were mediated through different modes of communication, as summarised in Appendix 2 (p266). Some participants used one sole mode—for example, Diane with email—whilst others' evolved during the course of the research. This latter scenario was the case for four participants: the first interview with Ben was via Skype and the second via email; for Gemma, the first was via email and second by face-to-face; and respective to both Isabel and Marie, the 'first' interviews were in the form of two email and the second interviews were conducted by telephone (I also received a third follow-up email from Isabel elaborating some themes further). The option to change the mode of correspondence was directly reiterated to participants by me if, for example, they commented on difficulties of continuing in the current manner or if delays of several weeks in their replies implied this might be the case. For instance, Isabel's second email included "[a]pologies for [the] slow reply - I want to help you and am ok about doing it, but am finding it difficult to find the time to reply". I subsequently enquired as to whether speaking by telephone would be preferable and we then arranged a time convenient for her to fit around other commitments including childcare. Similarly, the decision to move from email to face-to-face interview for Gemma pertained to having found the first interview email to be time-consuming given writing and editing on such complex topics. Although not stated overtly as such by Gemma, Marie or Isabel, the shift from email to face-to-face or telephone may also have been prompted by a wish for more synchronous and embodied companionship—such as the face-to-face presence, or vocal responsiveness enabled by telephone, of me/the interviewer—whilst they recounted distressing experiences.

Communication with participants concerned not only different, and sometimes multiple, modes of correspondence but also entailed various durations, rhythms and intensities. Some communications with participants were quite fast-paced (with only hours or a couple of days between replies) whilst others were slower (with weeks between replies from participants to my

follow up questions). This factor of interactional speed could impact on the quantity of time in total that correspondence between participants and myself extended, but other issues regarding depth and spread of discussion are also relevant to the temporal quality of these interactions. For instance, Fiona contacted me in early September 2011 and, after informed consent documents were processed, spoke about her miscarriage experiences. Fiona's emails were very prompt, in-depth and detailed—constituting 31 pages of email correspondence, excluding creative writing documents which she also shared with me—which allowed us to cover a great deal of topics. My replies to her tended to be somewhat slower as a consequence of my juggling multiple participants correspondence—continuing interview conversations, arranging face-to-face and telephone interviews, transcription—and the preparation I undertook each time before replying email participants of re-reading our communications to date. Fiona and I mutually agreed in December 2011 that we had reached a point suitable to bring the hitherto comprehensive and relatively fast-paced dialogue to a draw. However, much later, in August 2013, Fiona contacted me and we resumed discussion about some of the memorial activities and pregnancy loss support projects that she had been involved with since.

Owing to differences with forms of offline communication, online research methods require the negotiation and adaptation of 'traditional' methods as well as ethics (Hine 2000; Madge 2007). Different communication methods such as by telephone can also invite reflection on important questions regarding interviewing, listening and the use of transcripts (Cook 2009). Translating qualitative interview methods from largely offline, face-to-face settings to online and/or telephone contexts included, for instance, considering the pace of questions posed in asynchronous email interviews in contrast to those of face-to-face or telephone interviews. In the first email exchange interview, as with face-to-face and telephone interviews, I started by asking one very open question; 'could you tell me about [your experiences of pregnancy loss]' (Kvale and Brinkman 2008) was intended to allow the participant to elaborate as much or as little as they wished to. As with the other modes of communication, participants partaking in the email interviews tended to provide extensive elaborations of their experiences of pregnancy loss(es), thus highlighting a range of subtopics which I could follow up on. In subsequent email interview exchanges, I did not want to 'overload' participants with

questions, but equally I did not want to draw out the interview to such a slow exchange that participants would become tired of the research. As such, I tended to provide a handful of questions, allowing elaboration to the degree of the participant preference and sometimes requesting clarification.¹⁰

In addition to the implications for the style and pace of my questions, it is also apt to recognise that different modes of communication can shape participants' narratives. For instance, email interviews offer opportunities to edit out unintended or 'slippery' comments prior to being 'heard' by the researcher in a way that telephone, Skype or face-to-face dialogue cannot; however, as I will shortly discuss, written text can lack important tone and body language for clarifying intended meanings. Smith (2001 p34) highlights that qualitative interviews do not simply yield transcripts but are valuable also "for the conversation as it takes places". Partial speech, "utterances", without clear logics can be considered "a practice, knowable only as it is said in one context or another" (Smith 2001 p34). The differences between speaking- and typing-about one's experiences were sometimes brought to the fore when participants had engaged in multiple communication methods: comments made via one mode of communication may be disagreeable when revisited in another. For example, Ben distanced himself in an email interview from comments he had previously said over Skype and which I had reiterated in a question. This is not to imply that only one of these narratives, regarding his views on pro-choice politics, constituted his 'true' feelings and I recognise that misinterpretation by myself as the researcher is always a possibility; however, I believe that the example highlights the ways in which complex topics can yield different (and potentially conflicting) responses at different times. It also demonstrates that different modes of communication can permit various opportunities to reflect on what, and how, meaning is expressed: the implications of Ben's spoken comments when re-viewed as written text in an email provided an opportunity to reflect before responding and permit revision and nuance in ways that the flow of synchronous dialogue cannot easily accommodate.

¹⁰ Throughout the research exchanges, I attempted to clarify with the participants as to whether they considered the number of questions posed suitable and foreground that there is no rush to reply, that they did not have to answer all or any of the questions if they did not wish to, and that I was understanding of other commitments which might prevent them from replying for some time and/or require them to suspend participation in the research.

Another methodological concern regarding the different forms of interview communication pertains to the ways in which body language is apparent or not. As Parr *et al* (2005 p97) comment, “the words of human language cannot adequately do the work of representing many interior mental and emotional states”, and body language can often be very ‘telling’. It is not only in research interview interactions that body language and emotional conversing matters. Andrieu *et al* (2012), for instance, consider the use of body language, including gestures and physical proximity, as ‘quasi-linguistic’ when used to act out words in medical consultations. Owing to the sensitive topic, body language was particularly important for comprehending the emotional dimensions and personal significances of pregnancy loss experiences. In the context of email and telephone interviews, much of the body language which might facilitate and enrich a listeners understanding and the interaction between listener and speaker is obscured. This is because the embodied presence of interviewee and interviewer are hidden by the technological interfaces mediating their interaction and because email communication allows both parties to edit their messages. Whilst I agree with the importance Charmaz (2002) places on the need to attend to body language in relation to silences in participant narratives, doing so over the telephone (with time lags and sound quality disruptions) and emails (where communication is knowingly expected to be asynchronous and delayed) can be particularly difficult.

Beyond/Extra-linguistic Communication

In the telephone interviews it was usually possible to identify some vocal intonations and auditory-denoted embodied actions (such as sighs of despondency, tearfulness and/or crying) whereas email interviews largely lacked both bodily cues and evident auditory tones. In one sense, this meant that the intensity of feeling behind comments was not always immediately obvious and I was aware that uncertainty of tone could risk misinterpretation of words/phrases for both parties involved. Unintended evaluations of words and phrases can occur in all forms of communication, but I suggest that the lack of body language and vocal tone of online communication renders it particularly at risk of such an occurrence. Hence, in composing questions in email interviews, I was cautious about possible misunderstandings that may be conveyed and vigilant to try and minimise any assumptions in my questions and responses.

Although I carefully composed and checked my replies, the fact that some typos and grammatical errors remain in my dialogue highlights the ever evasive potential of ‘something slipping past’, although I am not aware of any significant misunderstandings actually occurring via the email interviews. As Markham (2004) encourages, alternate spellings such as ‘fetal’ and numbers such as ‘2’, and grammar present in participants’ words have largely been retained when quoted in the thesis, with a few occasions in which I have augmented with capitalisation of proper nouns, additional punctuation and context clarification in order to aid comprehension without significantly altering the excerpt.

Some participants drew upon typed conventions to render present some of the otherwise absent body language and tone ‘data’. Emoticons, for instance, were used in email interviews to stand-in for some kinds of emotional expressions which facial gestures or vocal tones might otherwise convey (Dodge and Kitchen 2001). Hall *et al* (2004) note that particular forms of language are often used within online groups with specific jargon, abbreviations and emoticons, some of which I found also emerged in the research interviews. For instance, participants sometimes abbreviated ‘trying to conceive’ to ‘TTC’, although other terms familiar and in use regarding pregnancy loss groups, such as ‘angel-versary’ and ‘rainbow baby’, were not mentioned in the interviews. Smilies like :) and :-D can be seen to denote friendliness within email interview text, and sometimes featured in the ‘chat’ before and after, akin to the general dialogue that tends to happen before and after a face-to-face interview is conducted. Similarly, the use of typed kisses like ‘xxx’, also indicating friendliness, emerged as some participants signed off (some of) their messages with these. I was aware that, in the absence of body language such as smiling and other friendly gestures, the use of typed kisses could indicate a level of rapport as advocated in much feminist methodology. I reciprocated where deemed appropriate, based on my assessment of case-by-case as to whether a suitable sense of closeness and care had developed or seemed to be developing.¹¹

¹¹ Although I do not agree with this interpretation, the use of typed kisses could be read as a transgression of ‘professional’ researcher-participant boundaries which, through my mirroring in emails, could be problematically read as encouragement. It may also have been the case that the x’s were not intended to ‘mean’ anything in particular but were habitual or accidental. The concern being that, if this was the case and I were to reciprocate signing off with x’s in my

Continuing on the theme of emoticons and typed details of bodily composure, humour and (occasionally simultaneously) distress were sometimes conveyed. For instance, ‘winking’ smilies were sometimes used, read alongside the wider context of the typed text and my general impression of the individual as built up through our dialogue, to signify sarcasm. For example, when I asked Graham to elaborate on his comment that “a huge proportion of people have seen me as little more than furniture”, he wrote back saying “I’m pretty good at reading [ultrasound] scans sideways on the angular limit for the screen these days ;-)” and mentioned some spatial dynamics at play in medical settings which tend to place partners like himself on the periphery during pregnancy loss (discussed further in Chapter 4). As they recalled their experiences, participants sometimes also typed details about their bodily demeanour and visceral responses which might otherwise have been evident in a face-to-face or telephone interview but not necessarily apparent via email. For instance, Isabel, speaking about the haunting image of foetal death at an ultrasound scan, said: “I will never forget the image on the screen of our little baby lying on his side so peaceful (thinking about it now is making me cry)”. In Chapter 6, I elaborate further on some other ways in which bodies and bodily processes feature in Internet-facilitated communications around pregnancy losses.

Benefits of the Multi-communication Approach

Despite anxieties and difficulties in translating methodological approaches, the research ‘data’ (narratives about experience) generated through the multi-communication interviews allowed me to attend to a range of topics. The temporal pace of email interviews, at the discretion of participants and my own abilities to respond, meant these often stretched over several weeks and even months. As a result, some participants experienced, and were able to discuss, major ongoing changes in their lives such as subsequent pregnancies, moving jobs, pursuing adoption and changes in relationship status as well as more minor events like recent events in their workplaces which could have a bearing on their feelings regarding pregnancy loss and their abilities to ‘talk’ in the research. Attending to the temporality of pregnancy loss experiences, extending prior to and after the actual ‘event’ of occurrence, was further

emails, it might draw attention to their unintended habit and cause embarrassment or make participants feel discouraged from the research, hence my careful consideration.

facilitated in the ‘stretched-out’ process of email interviews – allowing for reflections on different life events and changing future opportunities, if participants were willing. Although this was most easily facilitated by the frequency and ease of contact via email, it was also possible with multiple interviews by other communication forms (face-to-face, Skype and telephone).

I originally opted for multiple interviews to allow adequate opportunities to discuss what could be highly distressing experiences at a slower pace than a single interview would provide as well as for any clarifications. However, as mentioned, one helpful outcome of multiple face-to-face and telephone interviews was to permit discussions of a more longitudinal nature than one interview at a single interim point in time could. For instance, during our first face-to-face interview, Holly informed me that she was currently seven weeks pregnant with her second pregnancy after her first pregnancy ended in miscarriage. Echoing Rothman’s (1994) ‘tentative pregnancies’ and work on subsequent pregnancies after loss (Gaudet *et al* 2010; Côté-Arsenault and Donato 2011), Holly was acutely anxious about miscarriage during her second pregnancy and the ways in which the two pregnancies interacted became a key feature in our interview discussions. Temporality was crucial to this; Holly recognised her fears regarding her current pregnancy as she approached the stage at which she miscarried previously (nine weeks) and requested that we postpone our second interview until after this had been passed. When Holly and I met for our second face-to-face interview, she was 26 weeks pregnant and able to speak about—for example—how she had felt passing the ninth week as well as the 12 week/first trimester points and multiple scans. Such discussions would not have been possible had only one interview been conducted or if both interviews had been conducted in such quick succession to one another.

Alternative Methodologies?

Although interview methodology was chosen, I initially also considered online ethnography or netnography. This would have entailed utilising the online support groups to extract data about the topics being discussed and the ways in which users interact, allowing the discussions to be treated as textual data and thus potentially directly quoted. There has been debate, with diverging opinions, regarding the ethical propriety of conducting online research (Dodge and Kitchen 2001; Brownlow and O’Dell 2002; Clegg-Smith 2004; Jones 2004;

LeBesco 2004; Thomas 2004; Langer and Beckman 2005; Madge 2007; Seale *et al* 2010). Whilst Langer and Beckman (2005) argue that netnography is an ‘unobtrusive’ and useful method for researching sensitive topics, my primary reason for rejecting online ethnography pertains to an ethical discomfort with the presupposition that online communication is ‘public’ and thus available for intensive use in research. I persevered with seeking permission to post the CFP owing to my belief that this research required a sensitive and patient approach, despite my experience of the sometimes frustrating, drawn-out coordination with online group ‘gatekeepers’.¹² Subsequently, a two-layered consent was in action: firstly from the admins of the groups to permit me to post the CFP and, secondly, with completion of consent forms from each individual participant for interviews. Therefore, to additionally, or instead, ‘take’ the online discussions and interactions may well have yielded some interesting empirical and theoretical insights, but I feel it would have compromised my commitment to sensitive, feminist research in seeking to minimise exploitative power relations.

Seale *et al* (2010) suggests that there are differences between ‘traditional’ interview data and netnography data, finding that the former tend to feature the recalled past and anticipated future whilst netnography data entails more emphasis on the current ‘now’. However, Seale *et al* (2010) acknowledge that different temporal orientations could be built into interview questions to mitigate the differences observed. In my use of multi-communication and multiple interviews, I was able to minimise the loss of these purported ‘benefits’ of online ethnography data over interview data by conducting multiple interviews over periods of time and/or the longer-than-anticipated duration of email interactions. Whilst netnography is one way to ascertain insightful information about the online support groups (Hine 2000), interviews in whatever mode of communication can also facilitate exploration of these. As Hitchings (2012) argues, interviewing remains an important method for learning about participants’ practices. Thus, carefully directing conversation in interviews can potentially address similar topics to those being discussed in the online support groups, as was also the case with my interest in online activities (see Chapter 6). Deliberate questions yielded information about, for instance,

¹² Gold *et al* (2012) also faced difficulties in recruiting women from online pregnancy loss support groups in their questionnaire research, resonating with those encountered in my own such as difficulties obtaining permission from site owners and the quick turnover of group posts.

the interactions and practice of online support group users in ways which do not compromise informed consent and which continue to protect the anonymity of online users. Since it was important to have some familiarity with this in order to contact admin/moderators for permission and appropriately post my CFP, I have an informal knowledge and familiarity of the functioning of different online support groups which helped contextualise some participant comments about the online pregnancy loss support communities without a need for me to conduct what I consider to be ethically dubious netnography.¹³

Reflexive and Responsive ‘Ethics-in-practice’

Each of the aforementioned domains of feminist (politics, voice, power relations, positionality), sensitive (ethics, recruitment) and online/multi-communication (adapting existing ‘offline’ methods, tone, emoticons) research methods were important for my project. Across these, ethics have been crucial and relate to the ways in which ethical considerations ought to saturate research through all stages from the design of a project, to practice and in write-up (Dowling 2000). In this section, I will discuss how the three domains of literature regarding research practice were significant for considering my primary focus on bodies and embodiment in relation to the often already distressing topic of pregnancy loss. Whilst I hoped for the project *per se* to hold merit as a positive ‘intervention’ into otherwise silenced or silencing experiences, negotiation of harm and benefit regarding many aspects, including seemingly mundane actions and gestures, within actual research encounters remained crucial; hence, a reflexive and responsive ethics-in-practice was enacted.

Elaborating Themes in Interviews

As mentioned, pregnancy loss poses a threat to ‘squeamish academia’ in geography (Longhurst 2001) and, subsequently, I consider it a feminist research endeavour to bring elements of these lived experiences into focus which may otherwise be particularly prone to ‘silencing’ or ‘sanitisation’. With my

¹³ One way netnography could be rendered more ethically appropriate is through ‘ethnographic fiction’ (Angrosino 1998; Inckle 2005, 2010). For instance, Letherby’s (2012) conference paper outlined ongoing research with Deborah Davidson involving the combining of netnography with ethnographic fiction in the context of online pregnancy loss support groups.

particular research interest in bodies, I was conscious that some especially intimate and taboo topics would require extra care and sensitivity to broach. In the context of cemeteries, Woodthorpe (2010 p62) found that participants were often willing to talk about some aspects, like tending to the surfaces of graves, but retained “a simultaneous reluctance to discuss the reality of what was happening below ground”. In my CFP, I sought to clearly foreground an interest in bodily spaces and inter-bodily relations, linking to body surfaces, fluids/flows and interiors as well as emotions, memory and social attitudes. I am aware that this will likely have been off-putting for some individuals who may have been willing to participate in pregnancy loss research if it had a different focus. However, it is important to be open about the nature of topics that may be discussed in interviews. For me, this entailed the embodied materiality of pregnancy and pregnancy loss, including processes such as uterine bleeding, onset lactation and childbirth as well as physical engagements with bodily fluids and bodily materiality (of deceased embryos, fetuses and/or babies). In total, interviews were conducted with 24 participants and covered a range of topics involving different spaces, materialities, temporalities, bodies and relational experiences, as evidenced in the empirical chapters of the thesis (Chapters 3-8).

The broad opening question in the first interview asked participants to tell me about their experiences, presenting them with an opportunity to narrate in whatever manner, order, choice of words/topics and with disclosure of as much or as little as they wished (Corbin and Morse 2003). Often, participants were very forthcoming and required little to no additional prompts to elaborate, providing me with an ‘overview’ of their experiences which I could then ask about in more depth later in the interview or in the subsequent interview(s). This open-ended elaboration was also important in terms of informing me about the emotional complexity and dynamics so that I could (try to) become more attuned to certain aspects in participants’ stories around which there seemed to be hesitancy or omission and for which sensitivity was especially important. I kept an overarching topic guide with me at interviews along with, for secondary or additional interviews, a set of tailored topics/questions but I tried not to depend too much on this as a structuring framework for the conversational flow. Instead, I attempted to pick up on particular topics, sometimes making brief notes to aid my memory, which I could re-direct attention to when appropriate. As such, this constituted an open approach to the interviews, allowing themes to

emerge from participants' accounts and permitting them to direct the conversation in ways which they deemed significant. At the end of interviews, I asked whether there were any other topics, elaborations or clarifications which they wished to talk about, either in terms of being of interest in the research but also for their own benefit/welfare, and thanked them for speaking with me.

Adamson and Holloway (2012) comment with reference to themes of death and bereavement that some phenomena are particularly methodologically challenging to research. This pertains not only to emotional sensitivities but also the ways in which some topics are elusive, especially—as is the case for bereaved individuals thinking of the multifaceted ways in which the deceased are absent and yet present—if there is intangibility entailed (Adamson and Holloway 2012; Holloway and Jefferson 2000). Indeed, there were times within interviews when participants clearly struggled to find the words or expressions which would adequately convey their experiences, feelings and meanings regarding pregnancy loss and other life experiences. This relates to the ways in which many emotional experiences disrupt or otherwise elude “attempts to determine and specify meaning” with language and yet efforts continue not “in spite of this interval but rather *because* of it” (Harrison 2002 p591, p606; Parr *et al* 2005). Thus we must not disregard what individuals “*do* manage consciously to ‘say’ about what they think is occurring” in terms of their efforts to “find the words, or at least some words” and “bodily gestures as well as tired clichés and embarrassed mumblings” to ‘speak’ or communicate about particular experiences (Parr *et al* 2005 p98 *italics in original*). As such, I hoped for the interview settings to be spaces in which it was okay to ‘talk’ about experiences that might be otherwise marginalised or rejected in other social scenarios as with unsupportive friends or uncomfortable family members, whilst remaining aware that there are ‘speakability’ gaps and ‘legibility’ limitations.¹⁴

I was keen for the interviews to be opportunities for participants to talk as they wished and it seems that some participants found this to be the case. Heeding Adamson and Holloway’s (2012 p739) comments, I sought to be a

¹⁴ For instance, Victoria commented that she “just didn’t ‘feel right’” during her second pregnancy which later ended in miscarriage, reflecting that “[m]aybe it is woman’s intuition?!” As an elusive topic (Adamson and Holloway 2012), elaboration would be tricky but I encouraged Victoria to say more which, as discussed further in Chapter 3, yielded some limited expansion.

“sympathetic listener” and “provide support [...] [even if just by] being present” and/or by virtue of conducting the research. Given that pregnancy losses can be socially-isolating or marginalising experiences, I considered it all the more important that the research interviews go some way to counter this wider context. This led me to reflect on the ways in which, for instance, gestures within a research relationship and specific interview setting can embody ‘consolation’. A dominant, socially prevalent way of offering consolation such as for adult deaths is through condolences such as saying ‘I am sorry for your loss’. However, a plethora of emotional responses (Keane 2009), philosophical or spiritual standpoints on pregnancy loss make it unclear as to what would be appropriate for each person. In early points of contact with research participants, usually over email, I often had little to no contextual information which could support an informed decision as to what might be appreciated. Subsequently, efforts to cultivate the research and each interview encounter as caring and supportive were complex and ultimately ambiguous.¹⁵ During the research, with different individuals and at different times, I enacted a range of attempts to console and experienced a variety of responses. The concept of consolation, and attempts to knowingly incorporate this into a space and/or set of relations, highlights—I argue—precarity and need for flexibility which I consider to be pertinent more generally to social research ethics.

Negotiating ‘Sensitivity’: Minor Decisions, Major Consequences?

Relatively ‘small’ comments or gestures can have potentially ‘big’ implications within the careful negotiation to balance risks and benefits. As Irwin (2006) suggests in her paper on field relations, ‘micropolitics’ and

¹⁵ For those who initially emailed some details on their losses, I felt it could be offensive and even undermining of the project to withhold sympathies. However, I was aware that others may find such comments uncomfortable and/or highlight a disjuncture between different ways to understand and live with events of pregnancy loss. Appropriate consolation is a negotiation regarding how words or gestures are likely to be received. Consequently, since I have no certainty regarding the individual specific instances of my research, no concrete conclusions can be given that could function as guidelines for future researchers in their interview encounters. However, as with the literature more broadly around sensitive research (Corbin and Morse 2003; Kavanaugh and Ayres 1998; Lee 1993), my research experiences reiterate the importance of familiarising oneself with possible scenarios whilst remaining vigilantly receptive to unanticipated situations which one must try to negotiate to support research participants.

structural harm are not separate or unrelated. Rather, Irwin (2006 p169, p157) argues that intimacy can be “the vehicle through which we all reinforced larger structural relationships” and that being overly focused “on a litany of minor research decisions” can overlook this. Therefore, as I sought to exercise, it is important to retain recognition that relatively small gestures can also be embroiled in larger structural inequalities. Adding to the difficulty of negotiating these, I found that some scenarios featuring seemingly minor decisions with potentially quite significant implications could not be always be anticipated or adequately prepared for, despite heeding calls to remain vigilant to ethical or otherwise sensitive issues (Ramos 1989). As Kavanaugh and Ayres (1998) emphasise, enacting sensitivity depends significantly on the abilities of the researcher to assess and respond to the emotional state of participants. This also links to issues of researcher wellbeing (Rowling 1999; Hubbard *et al* 2001; Rager 2005; Sampson *et al* 2008). However, the emotional dynamics *between* participants and the researcher are subject to alteration with the risk of misinterpretation, making reflexive responsiveness both crucial and inexact.

Kavanaugh and Ayres (1998 p95) summarise that “[r]esearch interviews are inherently uncertain [...] [since] [n]either respondents nor interviewer can predict everything that will emerge during a research encounter”. Owing to this indeterminacy, I support an ethical approach which is reflexive rather than prescriptive and multiple rather than singular or dualistically ‘right’ or ‘wrong’ (Alty and Rodham 1998; Rowling 1999). As noted, a preoccupation with potential harm in research and attempts to “meticulously apply the many ethical codes in the literature” can, ironically, cause harm to the participants, the researcher and research produced (Irwin 2006 p164). Hence, during the research I strived to become more adept at handling aspects of encounters which I felt to be fraught or difficult. Emotional intelligence featured prominently here as I sought to translate ethical standpoints and preferences into research practice. However, this is always complicated by the fact that “emotions are never simply surface phenomena, they are never easy to define or demarcate, and they are not easily observed or mapped – although they inform every aspect of our lives” (Bondi *et al* 2005 p1). Although each interview encounter differed and there could never be any guarantee that I was doing the ‘right thing’, I learnt from past experiences, including those outside of the research such as in my volunteering experience and personal life, and my skills

in attempting to ‘read’ emotional dynamics and appropriately respond to the specifics were constantly being revised and adjusted in practice.

Flexibility was therefore a central component; for instance, as Kavanaugh and Ayres (1998 p95) state, “[t]he structure of the interview must adapt as necessary to the respondents’ need for pacing, such as taking breaks or postponing all or portions of interviews”. In addition, keen not to intrude on the scope for participants to direct and remain the focus of interviews, I sought to balance my role as a quiet or silent empathetic listener (Rowling 1999; Adamson and Holloway 2012) with my participation as a researcher asking questions for elaboration and clarification. The interviews and subsequent transcripts featured my voice encouraging and reassuring that I was listening (‘okay’, ‘hmm’, ‘yeah’) but I also tried to accept and respect the importance of some silences. Rather than seeing these as ‘voids’ to fill or as denoting failed comprehension, some pauses and silences can be saturation with meaning and constitute very ‘loud’ forms of “speaking in their “not” speaking” (Mazzei 2003 p356). Thus I support the notion that researchers must “be carefully attentive to what is not spoken, not discussed, not answered, for in those absences is where the very fat and rich information is yet to be known and understood” (Poland and Pederson 1998; Mazzei 2003 p358). Silences can highlight, for instance, occasions of thinking and gathering thoughts, hesitancy to speak, deliberate refusal to answer/respond to an objectionable preceding question or, linking back to the discussion of Parr *et al* (2005), an expression of the inadequacy of words. Silences, omissions and fragmentary or short responses from participants can also indicate that the topics being discussed are, or are becoming, ‘too’ difficult to think/talk about.

Assessing and Negotiating When Research Becomes ‘Too’ Painful

I am in agreement with Kavanaugh and Ayres (1998) that it is unacceptable for researchers to advance their research agendas knowingly at the psychological cost of participants. However, given that silences amongst other body language/gestures or vocal tones can indicate many different things, it can sometimes be difficult to know when (if at all), or how, to intervene. Since it is not only the content of participants’ experiences which can be upsetting but also the very questions of researchers (Kavanaugh and Ayres 1998), one response would be to altogether abandon a particular set of questions/themes. Within my

interviews, there were occasions in which I held back from particular lines of conversation when I felt that the participant would prefer not to discuss these due to being of an especially distressing nature, or it being the ‘wrong’ time. As such, “[s]ituations may arise that necessitate abandoning further investigation of any area that is too painful for the participant to discuss despite potential usefulness to research” (Kavanaugh and Ayres 1998 p95).¹⁶ It is difficult, however, to ascertain what exactly constitutes a scenario in which a topic is ‘too’ painful to talk about, linking to my earlier discussion on the ways in which some ethical approaches demonstrate an aversion to, and enact censorship of, signs of emotional expression which may in fact be cathartically valued by the participant. Since even tentatively asking whether someone felt able to talk about a difficult topic might induce a sense of obligation for them to do so, as well as cause upset (Kavanaugh and Ayres 1998), it is often at the researcher’s judgement as to whether or not to redirect the unfolding conversation.

Depending on the situation, it was sometimes possible to explicitly foreground the option to not talk about a topic within the question which, in addition, was always a choice throughout the research for all participants. At other times, I would tentatively repeat a phrase or comment the participant had previously made to invite elaboration but equally be amenable for them not to. In other situations, I made the decision, based on attempts to be attuned and vigilantly aware of (verbal, non-verbal/bodily, emotional) cues from participants (Corbin and Morse 2003 p347), to circumvent some topics altogether. However, retrospectively, I do not know if this was always the most fitting choice. For instance, I decided not to ask Isabel about her experiences of delivering a late miscarriage after interpreting a number of comments about privacy and embarrassment as cues not to ‘push’ the topic. Towards the end of our second interview, I was startled when Isabel queried why I had not asked and told me that she had been gearing herself up to talk about it:

Isabel: I was quite surprised though that you didn’t actually ask what, all about what happened on the day, about what happened

¹⁶ It is important to bear in mind that there can also be multiple tensions regarding harm and benefit between individual’s interests, collective interests and research interests. Hence, what may be considered ‘good’ for the collective may be harmful to particular individuals, as will be discussed briefly in Chapter 6 in relation to online disclosure/awareness of pregnancy loss.

when I had baby [surname], it's more about like emotions isn't it?

Abi: yeah, it's such a broad set of things I'm looking at, but if you wanted to speak more about what happened on the day – but, I wanted to sort of leave it up to everybody to decide how much they said about all sorts of things

Isabel: yeah

Abi: was that something you felt there was more to say about?

Isabel: erm well no I was just expecting you to go into, to ask more details about what had happened, what I went through sort of thing

Abi: in terms of the medical events?

Isabel: yeah, I 'spose, but, I 'spose you've got to be very careful about what you ask people and because you don't want to upset them and make it an unpleasant experience for them and put them off

Abi: hmm, hmm. Are the medical details things you do want to talk about, but haven't been able to talk about before, but would like to?

Isabel: erm... no, I 'spose not, it's just the terminologies really.

I tried to facilitate discussion on the physical experience of birthing which I previously thought constituted a topic that was 'too painful' for Isabel, as based on my reading of 'cues' of discomfort/reluctance. However, the realisation that I had been operating on this decision and my stilted response about it produced discomfort for us both which meant that it was not suitable to do so.

Learning from 'Failures'

I continued reflecting on the above interview experience, thinking about the decision I had made to not raise the topic, worrying about whether it may have been detrimental to Isabel and trying to make sense of the mixed emotions I subsequently felt (confusion, embarrassment, remorse). Whilst I initially saw it as an instance in which I had 'failed' as a competent social researcher, I later came to identify it also as a learning opportunity. In doing so, I found the comments of Nairn *et al* (2005 p239) helpful:

[i]t is important that we do not ‘write off’ data that initially does not appear to be useful, but re-consider it in order to find out more about who we are in relation to the people we research, the tenuous nature of the production of knowledge, and the struggles and desires we have as researchers[.]

Bondi’s (2005) encouragement to reflect on the emotional dynamics of interviews for practical, methodological and analytical reasons is again a salient point, as are Irwin’s (2006) comments regarding the ways in which power relations can be entrenched even as some ethical protocols are followed. This example can be understood as a scenario in which there was an incompatibility or disconnect between my reading of the emotional dynamics at play in the interviews and what Isabel expected/prepared to discuss. It speaks to the complexity of assessing emotional dynamics which neither ‘belong’ or ‘reside’ solely in me or Isabel, but are co-created and subsequently negotiated. This example also entails ways in which I had unintentionally imposed power relations between myself (the researcher) and Isabel (the research participant); it was I who made the decision not to broach this particular topic on the basis that I thought the balance between risk and harm swung most to the former. Despite theoretical familiarity with themes of feminist research, seeking to equalise power relations and ‘give voice’ to participants, the decision was rather paternalistic: made *by* me *about* Isabel and without any open consultation *with* her regarding this. Whilst the decision had been well-intentioned, to protect another from possible harm, and Isabel herself recognised this (“I ‘spose you’ve got to be very careful about what you ask people and because you don’t want to upset them”), it ultimately negated her right to participate in this decision-making process, thus reinstating my own power in the research.

Prior to this situation, it had not occurred to me that Isabel was expecting and perhaps even hoping to be encouraged to talk about particular aspects by me. Motivations behind participation are often multiple and varied (Clark 2010); I was aware that participants may be drawn to contribute as an opportunity to talk extensively to someone (potentially preferably a stranger) in contrast to a lack of other opportunities in their wider lives to do so. In addition, a frequent comment made about taking part in the research was the possibility that doing so might be of benefit to others with similar experiences. Hence,

participating in research potentially provides “a forum [in which] to engage in socially valued activity, including teaching, informing, and generally displaying the possession of special knowledge” (Miczo 2003 p484). At this point I had not yet considered in sufficient depth that, in contrast to being dismayed by the overt emphasis on bodies in my CFP, perhaps it was the challenging nature of this that some people were interested in exploring through talk in their own lives and/or for the possible benefit of future/unknown others. In thinking that my omission of the topic was complicit with Isabel’s preferences and that this was in fact a sensitive, respectful thing to do – I consequently closed down an avenue for discussion that the participant (at least during the second interview) had in fact wished to pursue. This example therefore alerted me to the complexity of reading emotional dynamics, enacting ethics in practice, the unintentional reinstating of power relations and the risks of perpetuating emotional aversion, silencing or censorship in one’s research.

Research Agenda

About Analysis

An iterative approach was used to analyse the data, facilitated by multiple interviews, in which I drew upon the emphasis in grounded-theory on understanding emerging out of the research data rather than hypotheses ‘imposed upon’. Although a relatively small number of participants were interviewed, vast amounts of data were generated owing to the length and use of multiple interviews. Adamson and Holloway (2012) suggest this presents a challenge encountered by many qualitative researchers on bereavement. Whilst the abundant quantity of data generated, in the form of interview transcripts and photographs/creative writing sent by participants, prompted uncertainties about how to best utilise this material in analysis and write-up, it was also incredibly qualitatively rich, allowing me to attend to a range of themes and examples. Empirical chapters draw heavily on participants’ interview narratives, often focusing on a few individuals whose experiences were particularly relevant to the themes under consideration. Subject matter varied between interviews, tailored to the context of the participant’s experiences and negotiated according to the emotional dynamics and ethics-in-practice; likewise, the depth/length of talk about topics differed. Since the research aspired towards understanding rather than a representative sample (Valentine 2005), I do not consider this to

be a hindrance. Subsequently, my approach in the interviews—as with analysis—was flexible and open to exploration, following research ‘threads’ rather than systematically pursuing answers to set questions/problems. This ethos resonates with Agee’s (2009) description of the constant (re)developing of research questions permitted within qualitative research which can entail a dynamic and multi-directional approach with processes of reflection, iteration and dialogue. Analysis, therefore, involved interwoven and looping practices of coding, interviewing, reading, theorising and writing.

As with research design and practice, sensitivity is of paramount concern and I sought to treat participant narratives in a careful and considerate manner. At times, however, I am conscious that the academic and/or medical language I use may be unfamiliar or unsatisfactory to some participants, such as when I refer to an ‘embryo’ when the participant tended to use/would prefer ‘baby’. I have attempted to reconcile this with the use of quotes whilst simultaneously seeking to manage my comments within a context which I am acutely aware is peppered with issues of reproductive politics. In addition, I realise that participants may feel that I have misunderstood or examined some of their quotations in ways which they did not intend. It is not my intention to cause upset to participants, whom I am extremely grateful to for contributing to the research, and I openly recognise that I may well have misinterpreted comments despite best efforts to avoid doing so. At times, I have examined some quotations and examples through a critical lens to highlight tensions, ambiguity or contradictions. As Adamson and Holloway (2012) comment, it is important that researchers do not take interview narratives purely at ‘face value’ and naively celebrate them; rather we must also consider how politics (discourses, power struggles, boundaries) may be at play. I hope that participants understand that this is not intended to cause upset and appreciate the value of such academic inquiries, with potentially wider implications, which are inevitably connected to my own evaluations and views such as on termination.

Analysis was ongoing throughout the research as I listened during (or, in the case of email, read) the interviews/exchanges, transcribed, annotated as part of coding, prepared for subsequent interviews events/exchanges and wrote-up. Using multiple interviews when participants permitted provided additional impetus to reflect on areas for clarification, elaboration and any new themes

that may have emerged. There was a dialogue between data generation and analysis as they inform one another: particular themes present in my interview questions were sometimes complicated or nuanced in the narratives of participants and their transcripts, allowing for other code categories to emerge which might then direct further inquiries within subsequent interviews subject to further nuance. This was also the case *across* interviews with different participants, as topics emerged in interviews which I had not previously intended to ask about/considered relevant, allowing opportunities for me to incorporate these into interviews with other participants for whom the topics might also be germane. As such, I drew upon grounded theory in my approach to research practice and analysis, allowing themes to emerge from the data rather than using the data to ‘test’ predetermined hypotheses, and seeking to identify gaps to further inform data collection. Linking back to the previous discussion on ‘silence’, I also sought to remain attuned to omissions, absences and what is not spoken (Adamson and Holloway 2012).

Concluding Remarks

I have outlined several underpinning interests which have shaped my choice of methods, conduct of research practice and subsequent use of generated data. This involved drawing together: feminist research practice; sensitivity and care whilst not imposing prohibition or silence; and the use of multiple communication modes for interviews (face-to-face, telephone, Skype, email). My approach to reflexive and responsive ethics drew upon dimensions of these feminist, sensitive and multi-method research contexts, shaping the ways I have approached thinking and talking about particular topics and tensions. The importance of emotional dynamics has been present throughout my discussions on methodology, alongside recognition that there can be no guarantee that balance will always be achieved between risk and reward, harm and benefit. Openness about such methodological processes, some of which with hindsight might have been handled differently, facilitated my attention to a range of considerations. This concerns not only the emotional impacts of research on participants and researchers but that emotions can constitute a valuable interpretive and analytical resource (Bondi 2005) which I sought to utilise throughout the thesis in the forthcoming empirical chapters.

Chapter 3: Bodily Interior Geographies of Pregnancy Loss

Introduction

Reproduction is now a highly medicalised and technologically-mediated experience for many in contemporary Western societies, encompassing aspects from egg harvesting, conception, pregnancy/gestation, to labour and delivery (Ginsburg and Rapp 1991; Rothman 2007a, 2007b, 2007c; Simonds 2007a, 2007b; Simonds and Rothman 2007; Cherniak and Fisher 2008; George 2008; Kirkman 2008) as well as beyond (see Godderis 2010 on postpartum depression). The medicalisation of pregnancy, with the widespread use of reproductive technologies such as ultrasonography, can be seen to participate in constructing the foetus as ‘patient’ and ‘person’, potentially marginalising women involved in the process (Woliver 2002; also Casper 1999 on the production of patienthood in foetal surgery). Evidenced in my own research, biomedical interventions and knowledges are often also core to experiences of pregnancy loss. For example, many participants had attended official medical spaces like GP surgeries and hospitals, sought medically ‘legitimate’ information, and undergone tests/procedures including medical and surgical miscarriage management. However, biomedical approaches to interior bodies in pregnancy losses are not the only, nor necessarily the most desirable, way to understand such bodily experiences and events. This chapter will consider some of the processes, movements and sensations of the ‘bodily interior’ in pregnancy loss experiences, drawing upon literature and empirical material attending to themes of medical technologies (visual, diagnostic) and sensory knowledges.

The medical model positions medical workers as ‘mechanics’ in relation to ‘broken’ machines, rendering the patient an *object to be acted upon* (Rothman 2007b). Martin (1987) also suggests the metaphor of the factory owner supervising labouring women’s ‘machines’ (uteri). These metaphors, mobilised in medical practice, have a propensity to disavow particular aspects of ‘lived’, ‘felt’ bodies and experiences of patients, for instance, dismissing emotions and relations with other people as subjective or irrelevant (Martin 1987). The image of Nilsson’s *Life* magazine cover in 1965, Michaels (1999) argues, introduced ‘middle America’ to a particular representation of the interior womb, since which numerous other images and discourses ‘revealing’ pregnancy have proliferated. Internally felt sensations in pregnancy are now

likely to be explained through the “interpretive frame provided by biomedicine”, rendered intelligible and (re)confirmed through measured outcomes of ‘evidence’ (Abel and Browner 1998 p321). Medical lexicon thus features “vividly both in women’s perceptions about how medicine views their bodies and in how women view their own bodies” (Martin 1987 p14). Duden (1993) highlights a historical shift in privileging knowledge about pregnancy from that directly-experienced and pronounced by women (quickening) to that visualised and pronounced by ‘medicine’ (ultrasound).

In this chapter, I will outline the dominant ways a medical model lends to conceptualising pregnant bodies as signifying disorder, danger, abnormality and risk (Lupton 1999; Rothman 2007b, 2007c) and which justifies medical-technological ‘access’ to bodily interiors. I will then consider medically-sanctioned ways of confirming and tracking pregnancies, focusing on urine- and blood- hCG detection tests before discussing ultrasonography spaces and accompanying waiting rooms. In addition to employing widespread ‘objective’ medical knowledges, some participants mentioned sensations and elusive feelings akin to ‘intuition’ which can potentially evade biomedical framings. These latter aspects will be discussed as participating in ‘feeling’ pregnant and no longer ‘feeling’ pregnant, including experiences of transitioning from ‘pregnant’ to suspecting, anticipating and accepting pregnancy loss.

Biomedical Approaches to Bodies and Bodily Interiors

Whilst knowledges gleaned through biomedicine, including for preventing and treating pregnancy losses, are clearly important, medicalisation can result in the objectification and fragmentation of patient bodies into mechanical components. Rothman (2007b p7) describes the medical model as one in which “[p]roblems in the body are technical problems requiring technical solutions”. In the ‘heroic’ depiction of medicine (Casper 1999), the ‘sick’ body is a system of material parts and processes which can be overridden through the administration of drugs, replaced or otherwise ‘fixed’. However, this approach means that lived, emotional, holistic body-selves, including the identity beyond the patient role, can easily be overlooked (Martin 1987). Subsequently, work in the medical humanities has offered critiques of the reductive approach to bodies in biomedicine and, though by no means the sole investment (Pattison 2003), encouraged efforts to ‘re-humanise’ medical practice through training. Yet the

implications of the dominant approach to bodies as objects remains a cause for concern, particularly for feminists conscious of the ways women's pregnant bodies especially have been subject to monitoring, control and discipline (Lupton 1999; Shildrick and Price 1999; Lupton 2011).

A set of long-standing gender-biases around what constitutes a 'normal' body, reformulated and concretised through the proliferation of risk discourses, renders pregnancy a state of 'abnormality'. Rothman (2007b p8) argues that:

[t]he source of the pathology orientation of medicine toward women's health and reproduction is a body-as-a-machine model (the ideology of technology) in which the male body is taken as the norm (the ideology of patriarchy). From that viewpoint, reproductive processes are stresses on the system, and thus disease-like.

The perception of pregnant embodiment as dysfunctional (Young 1984) and risky (Lupton 1999) appears to stem from the normative assumption regarding the 'healthy' and 'stable' masculine ideal (Eckman 1999). The kinds and rapidity of bodily changes during pregnancies (and affected behaviours, like the more frequent need to urinate) are considered 'abnormal' in contrast to the relatively static male human body. Consequently, pregnancy is considered "a perilous journey, requiring eternal vigilance [and compliance with medicine] on the part of the woman travelling through it" (Lupton 1999 p66). Rhetoric of risk thus justifies constant surveillance and mitigation, chiming with historic perceptions of the pregnant body as effectively ill/sick, disordered and dangerous.

Feminist accounts have critiqued the institution and practice of medicine as characterised by masculinist, patriarchal legacies (for example: Spallone 1989; Rogers 1995; Rothman 2007b). This is not to suggest that *all* medical encounters are sexist or that the binaristic scenario of cis-male doctors in relation to female patients monolithically holds. However, now underlying the practices of 'gendered medicine', particular patriarchal values and norms were historically foundational (Lorentzen 2008). This includes the delegitimising of female birth attendants with the scientific professionalism of male doctors markedly during the eighteenth-century (Donnison 1988; Carter and Carter 1994; Parker 1996; Simonds and Rothman 2007; Rothman 2007b). During the

1960s, the midwifery model and women's health movements developed in resistance to the medical approaches towards pregnancy and birth (Burt Ruzek 1978; Layne 2003a, 2003b; Rothman 2007b). However, in (over)emphasising the happy outcomes of pregnancies as controllable, natural and joyful, women's health movements have arguably contributed to the dismissal and silencing of pregnancy loss events and their socio-emotional impacts (Layne 2003a, 2003b). However, this is not to ignore that, at the other end of the spectrum, "[e]arlier and more intensive medical management of pregnancy encourages earlier and more intensive social construction of foetal personhood in wished-for pregnancies and to the view of pregnancy as something that can and should be controlled" (Layne 2010 p103). It seems, therefore, that both the medical and midwifery models of, and practices regarding, pregnancy and childbirth can have difficult implications in the context of pregnancy losses.

Women's uses of reproductive technologies are complex and ambivalent (Kirkman and Fisher 2008; Lorentzen 2008; Gorenstein 2010; Layne 2010a). As Casper (1999 p104) states, many women have had disquieting experiences pertaining to the disciplining surveillance of their bodies via medicine, yet some still welcome medical 'intrusion' "if it means better prenatal care and healthier babies". Lock and Kaufert (1998 p2, italics in original) note that women's engagements with medicine can range from "selective resistance to selective compliance, although women may also be indifferent", arguing:

women's relationships with technology are usually grounded in existing habits of pragmatism. [...] If the *apparent* benefits outweigh the costs to themselves, and if technology serves their own ends, then most women will avail themselves of what is offered.

Thus, the nexus of medicalisation, feminism and pregnancy loss is fraught. Medicine can prevent *some* (but not all) pregnancy losses and treat *some* aspects that go 'awry' (Jenkins and Inhorn 2003), including around gestational diabetes, placenta praevia and pre-eclampsia. However, the acceptance of (or desire for more) medical involvement in pregnancies is accompanied by risk discourses that demand further submission to the control of medicine, with potentially blame-inducing and punitive consequences for women if/when their pregnancies result in, as Layne (2003b) terms it, 'unhappy endings'. The

perspectives of participants about medicine (actual as well as hypothetical encounters, procedures and potential future medical advances) in relation to pregnancy losses were diverse and conveyed a range of perspectives about bodies, reproduction and agency. Participants' experiences of pregnancies and pregnancy losses included a variety of medical aspects, including the very modes through which pregnancy is potentially achieved, such as conception through IVF. For different women and in different circumstances, some forms of medical technology were actively sought and sometimes enjoyed, such as receiving a wanted 'positive' pregnancy test result. It was not the case that all participants in this research simply or wholeheartedly rejected nor embraced biomedicine, but rather their reproductive health experiences often entailed different elements on a "fuzzy, shifting continuum" (Casper 1999 p104).

Still, many participants felt their experiences of medical settings and procedures compounded the distress of pregnancy losses. Numerous participants described feeling disempowered and incredibly distressed by the medical experiences undergone, sometimes by highly phallic medical investigation tools. For Caroline, when a foetal heartbeat could not be located using standard abdominal ultrasonography, a transvaginal ultrasonography probe was used. Caroline recounted "invasive" repeat experiences of this alongside other medical encounters such as a hysterosalpingogram to check for fallopian tube blockages and with three of her four early miscarriages managed by Dilation and Curettage (D&C).¹⁷ These experiences can be considered to constitute "micro-spatial invasion[s] within the macro-spaces of the medical environment" (Bingley 2012 p78). Using the language of phallic penetration, Caroline described transvaginal ultrasound probes as "a long thin willy basically of hard plastic and they put like a condom over it and then they insert it inside you, so basically you're just opened". She described a harrowing occasion when a transvaginal ultrasound was requested in a routine (12 week) scan:

I said 'okay, fine', not realising anything was wrong at all, thinking 'oh, he just wants a closer look', and he actually told me that the baby had died whilst he had this thing inside me [...] I'm lying

¹⁷ D&Cs and ERPCs (Evacuation of Retained Products of Conception), now collectively known as Surgical Management of Miscarriage, are surgical interventions in which the cervix is dilated in order to scrape and/or aspirate the uterine contents.

there with my legs splayed open... yeah, with this THING stuck up me which he's prodding around and I... I... I... I just, WELL, you can imagine.

The use of anaesthetics meant that Caroline was not awake during the D&C procedures, prompting a poignant and chilling uncertainty regarding invasive medical technologies whilst unconscious. A sense of her body being violently treated as a mechanical object was highlighted in Caroline's comments:

because I don't know what they're doing [when anaesthetised] but I know my legs are splayed all over the place and they've got clamps and all sorts up me to open up my cervix, to DRAG out whatever is inside, you know, that's invasive.

Such medical procedures, therefore, are not merely neutral practices of 'knowing' about bodily interiors but markedly shape the emotional experiences about pregnancy losses as recalled, for instance, in research interviews.

Medical 'Knowing'

The medicalisation of female reproductive bodies produces particular knowledges about, as well as physical access to, bodily interiors. This includes: the removal and implanting of reproductive matter, including egg harvesting and embryo transfer; the measurement/assessment of interior processes, such as from the blood and urine; genetic counselling; diagnostic visual technologies like ultrasonography; and foetal medicine. In this section, I discuss urine hCG tests, mentioned by most participants, as a form of medically 'knowing'. These tests work by detecting the hormone human chorionic gonadotropin (hCG), produced following egg fertilisation, in the urine. As Layne (2010b) notes, urine pregnancy-tests are a medical technology which has moved from being only accessible in medical spaces to now prolifically available. As a 'domesticated' medical technology, these urine tests are now used in 'non-medical' environments such as toilet spaces at home, work or the supermarket. The near-ubiquitous use of urine pregnancy tests in Western societies pertains to mutually reinforcing availability in pharmacies/convenience shops and the socio-emotional status of the test. These tests can partake in the production of foetal identity/personhood and, though only Caroline mentioned doing so for

her first miscarriage pregnancy, used tests may be kept as a ‘memento’ akin to ultrasound images and postpartum artefacts such as the first lock of hair.

Urine Pregnancy Test Kits Outside of Medical Settings

The emotionality of using urine test kits at home for pregnancy detection was a prominent theme in many participant accounts. For some, the repeated experience of miscarriages and/or arduous infertility treatments tainted pregnancy tests with simultaneous dread and excitement. Participants held different notions about when it is suitable to test in relation to missed menstrual periods. Victoria conveyed the intensity of this for a much-wanted pregnancy: “I did a test on the first day of my missed period, I was desperate to do tests before but I held off until the day I should have come on [menstruating]”. Marie reiterated a similar sentiment:

I’ve never tested early in the whole three years [of trying to conceive] because... it’s really hard not to {laughs} believe me it’s really hard not to [...] [but] I think you have to get to the day you were due and at least miss by a few days.

As such, many of the women felt there are emotional risks around home-testing early for desired pregnancies. However, Caroline developed a routine in this way so as to gather data (the quantity and timing of repeat miscarriages) in order to secure medical support for what she suspected was ‘sticky blood’ syndrome. Caroline explained that she began testing several days before her period was due because “the recommendation for the treatment anyway is that you [are required to] test early, so I was, I cottoned onto this”. Whilst this is what she did, using it as a strategy “to prepare for the next anticipated loss” (Layne 2010b p103) and pre-emptive of biomedical investigation, Caroline cautioned against others doing early testing (“but you shouldn’t, no, no”).

Acutely aware of the emotional dimensions, several participants described their cautiousness about, and occasionally made pleas (rhetorically to unknown others and directly to me) to defer, the use of urine pregnancy home test kits. In a subsequent interview, Caroline reiterated her belief that this readily-available technology has altered pregnancy experientially which, as Layne (2010b) also argues, brings the frequency of early pregnancy losses to awareness. Caroline explained:

if you think back, sort of, 30 years ago when you got pregnant, you waited till you missed probably TWO periods and then you went off to the doctor and you got a result whereas now if you're four days before your periods due, you go off down to the chemist, you buy this great kit that will give you very early indications that you're pregnant [...] and what you need to remember is that the majority of these pregnancies sometimes end and you have your period as you would normally have your period and you would have been none the wiser, that's nature, you know.

Caroline felt it was “dangerous for women to assume [...] they've had a miscarriage before their period was actually due because 30 years ago you wouldn't of known you were pregnant”. Resultantly, she considered testing before a due period as “setting yourself up for a heartache”. This resonates with Layne (2010b p102), that the “[u]se of the home pregnancy test means that women who in the past would have been spared the experience now must deal with a loss, and do so in a culture that denies and belittles this experience”. In both sets of comments, there is a tension and indeed Caroline recognised that she might sound “quite heartless”. Certainly, technologies such as urine test home-kits enabling ever earlier chemical detection can mean that a particular pregnancy is invested in emotionally at an earlier stage than previously. However, the notion that one might be better off not knowing could denigrate (some) pregnancy losses and resonate with trivialising historical, as well as contemporary, social responses to individuals who lose pregnancies. The notion that ‘you could never have known’ risks reconfiguring the dismissive ‘better luck next time’ comment (Letherby 1999), especially for women whose much-wanted pregnancies never progress past this early biochemical point. Thus, Caroline's and Layne's (2010b) comments can appear complicit with particular trends of the social policing of pregnancy loss grief in assuming ‘ignorance is bliss’.¹⁸

¹⁸ Layne (2010a) acknowledges that a reviewer also raised the issue that postponed testing could deprive some women who might value the opportunity to know that they were pregnant, even if this be only short-lived. Sharing this concern, I prefer the approach later on in Layne's (2010b p108) chapter in which she advocates early pregnancy detection by ‘self-knowledge’ and suggests a “feminist pregnancy test” which would include information on an array of topics, such as on miscarriage, termination, contraception and infertility, for *different* women.

The example of urine pregnancy tests highlights some tensions and ambivalences surrounding the use of medical-technologies which are inseparable from the wider socio-cultural contexts of their design and involvement in a multiplicity of practices (Johnson 2010; Jutel 2011). For some participants, such tests can be distressing and were recognised as only ever precariously ‘truthful’; for others they could be exciting and informative, resonating with Gemma’s experience of her first pregnancy:

I always think there’s this interesting thing about pregnancy tests where you almost feel like... you know, I’m kind of goal-orientated {laughs} and with these tests you kind of feel like you’ve won or something {laughs} you’ve achieved it, you get the plus, you know, it’s like getting an ‘A’ [grade] {laughs} so I don’t know if it was as naive and simple as that and I still think that with the subsequent pregnancies as well, I think ‘*I’ve got to get the line*’ {laughs}

Urine pregnancy tests, it seems, are tied up with wider discourses about ‘achievement’ and ‘success’ as well as notions of motherhood and gender propriety. Subsequently, it can be devastating to see a negative pregnancy test result when hoping for a positive (Abbey 2000). As Marie explained:

I didn’t want the disappointment, I didn’t want to see that negative, to not get the lines [...] it’s difficult to... to... it’s disappointing enough as it is when your period comes when you’re trying, but then to have a test and it’s negative AND THEN your period comes – it’s like a double whammy.

Successive menstrual periods, even if one is not trying to conceive at the time, can bring back emotions and memories of pregnancy losses. Penny, having experienced a diagnosed missed miscarriage at 12 weeks after trying to conceive for nearly a year, remarked: “every time [I’ve] had a period[,] it makes me feel sad and emotional as it feels like another reminder of the fact [I’m] not pregnant anymore”. The biomedical depiction of menstruation as “failed (re)production” is therefore painfully felt in such scenarios of wanted pregnancies (Martin 1987 p105), with the devastation of ‘innocent’ mentalities regarding pregnancy (Layne 1996, 2006) and dispositions of ‘invulnerability’ (Janoff-Bulman and Berger 2000) constituting additional ‘losses’.

Using urine pregnancy tests can be highly emotional endeavours with effects that far exceed ‘merely’ yielding medical (chemical) information. This is the case for much-wanted pregnancies, as for Marie and Penny, but also for pregnancies neither planned nor necessarily wanted following contraceptive failure. Carla described finding out that she was pregnant for the first time as a young teenager, to which her best friend, unaware that she had been sexually active, thought she was joking as they were only “little kids”. Shocked and in denial about the results of the urine pregnancy test and, owing to being under the statutory age of consent, Carla feared that both she and her partner would be in legal and familial trouble. Eventually, over a couple of months, her mother noticed that Carla was no longer asking for or using a supply of tampons:

she collared us and went ‘[Carla], ‘are you pregnant?’ and I was like ‘I don’t know’, [I] blatantly knew—crap, there’s something in me—but naively thought if I ignored it, it’d disappear. [...] But no, erm, my mam took me to [a supermarket], [I] peed on a stick, two pink lines appeared INSTANTLY, my mam was like ‘maybe it’ll disappear’ [...] bless her {laughs} it was like no mam, once they’re there – they’re there forever.

In this instance, Carla’s pregnancy culminated in the birth of her living child; however, as in her subsequent miscarried pregnancies, the visible positive pregnancy test lines are not always guarantees of pregnancy outcomes. Holly commented that she wished “there was a test they could do that just says ‘you’re pregnant but actually it’s not going to happen so prepare yourself for that’ erm... or ‘you’re pregnant and it’ll probably be okay’ {laughs} I realise that’s not going to [happen]”. Since urine home tests “fragment, isolate, identity, and measure a single element of these [incremental and multiple pregnancy] changes” into the presence of the chemical hCG, they can thus mask over the complexity of what may be occurring – including non-viable pregnancies (Layne 2010b p97).

In addition to an inability to determine viability or pre-empt loss, several participants expressed hesitancy or scepticism about the quality of urine-test kits, including that the tests are not scientifically infallible regardless of the perceived quality of the brand. Home-use kits are not always considered to provide ‘authoritative knowledge’ as “women often do not trust the result of the test either because they believe the product may be flawed, or they fear they

have erred in using it and so perform repeat tests” (Layne 2010b p95). With initially very faint results on a twin pack of supermarket tests, as “there seemed to be something almost there where I needed the line to be, but I wasn't sure”, Helen used a variety of brands as she re-tested. Later that day, she “bought a fancy expensive test” but:

to my dismay, the test was inconclusive and hadn't worked for some reason. So, I called into [another] chemist [...] and bought 2 cheap strip tests [which were again faint] [...] I bought another twin pack from [supermarket] a day or two later and got a much clearer line[.]

Helen articulated her mixed emotions as she sought a reliable test result across a variety of brands with different cost-quality connotations and that “[as much as I was willing the line to appear, I was also scared of that line and all that it would lead to. I hadn’t expected that facing miscarriage was one of those things though”. Whilst urine test kits can offer *some* insight into the internal processes at work within women’s bodies (chemical pregnancy or not), they cannot inform of the viability and physiological context of the pregnancy which could end in a matter of only hours, days or, due to a lag before bleeding, already have done so.

Pregnancy Tests Within Medical Settings

Despite praise that urine pregnancy-tests available to purchase in stores can decrease dependency on medical institutions to manage reproductive choices (Oakley 1976, quoted also in Layne 2010b), many women still seek and appreciate medical institutional legitimacy. The evidenced-yet-precarious status of a positive result arrived at through urine-based home-kits prompted many participants to visit their GPs for blood tests, and/or additional urine tests, and ‘official’ confirmation. Thus, professionally trained individuals instated in spaces coded as ‘medical’ were sought to authoritatively affirm pregnancy as well as to provide access to particular resources like contact with a midwife or termination referral. Resultantly, ‘learning’ that one is pregnant is now very much “a multistep, technologically dependent, diagnostic process [...] [in which] not one, but two and often more scientific tests are undertaken. Home diagnostic kits do not replace doctors’ tests; they are just an additional, prior step” (Layne 2010b p96). After conceiving on the fertility drug Clomid and

positive home-kit urine tests, Esther visited her GP where she then had blood tests taken and an external examination. However, the legitimacy attributed to medical professionals is sometimes challenged. Esther's GP referred her onto a local EPU with suspected ectopic pregnancy for an ultrasound, although the validity of her GP's approach was contested: "if you've poked me, it hurts because you've poked me – not because there's a problem". On arrival, the EPU refused a scan, providing blood tests instead, and an ectopic was ruled out, adding to Esther's scepticism about her GP's examination. Whilst the examination was discredited as unable to provide biomedical 'fact', the blood test results came to feature prominently in Esther's experience.

Esther was telephoned later that day by a doctor at the EPU to inform her that her hCG blood tests likely indicated an ended pregnancy: a finding which, although mixed with disbelief and disappointment, turned out to be the case. The delivery of this information was coarse: "I kid you not, his words to me were 'your hormone levels have dropped, your baby's not viable, you need to come in in two days for another blood test'". Subsequently, though dubious of the medical validity of the external exam, Esther described her rapport with her GP in much more positive terms than her experiences, stretched over nearly two weeks, with EPU staff. In addition to denying her request for a ultrasonography scan and the brisk phone call, Esther's experience at the EPU included: multiple (excessive?) blood tests; being left her in waiting rooms for long stretches of time, on one occasion, being told she was "forgotten about"; 'cold' staff communication; and insensitive/non-consenting exposure to what both parties knew would likely be an ultrasound image of foetal death. In contrast, Esther's GP conveyed a degree of emotional care by being "a bit more human certainly". The relationship with her GP had built up over time—from initial fertility investigation, confirming the pregnancy, referring to the EPU—and, after her miscarriage, the GP "remembered us... and obviously our history and what had gone on in the past and stuff and yeah she was very, very good, very compassionate and very kind". Thus, whilst there is an expectation that medical staff should be proficient in deploying their medical knowledge (through forms of medical assessment) – a sensitive, understanding demeanour was also important and, as in Esther's evaluation of her GP, could potentially compensate for medical uncertainty.

Blood tests offer an informational advantage over urine-test home kits in that the hCG count can be numerically tracked and interpreted in line with the curve of levels for normal pregnancies, peaking around 10 weeks since last missed period (Beischer *et al* 1997). An unexpected stagnation or dropping of hCG levels can indicate miscarriage in advance of the onset of uterine bleeding. Thus blood tests were sometimes used to check for ‘completed’ miscarriage in with hCG levels return to a ‘non-pregnant’ baseline. Beth’s knowledge as a doctor aided her understanding as to why urine or blood pregnancy tests might yield positive results despite uterine bleeding indicative of miscarriage:

my GP made me do a pregnancy test in the office while I was bleeding. I guess he wanted to prove that I was pregnant at all and that this wasn't my period, but as the pregnancy hormones hang around for a few weeks post miscarriage/termination etc. a positive result did nothing but upset me and confuse my non-medical husband.

The testing was emotionally distressing despite her medical understanding and Beth recognised that this could be especially so for ‘laypersons’:

I was then even more upset thinking about all the other women who might have a pregnancy test like that and think it meant they were still pregnant when in a lot of cases they weren't, and then I had to wait 2 days for a scan (knowing all the while it was likely going to show no baby, but some women would have hung onto that positive test).

Subsequently, the meanings yielded by positive pregnancy tests, whether the ‘achievement’ described by Gemma or the definitiveness remarked upon by Carla, become particularly complicated in some instances of pregnancy loss.

Blood tests involve physical elements of pain/discomfort and additional layers of psychological distress, including needle phobia and of bodily invasion. These entail direct ‘touch’ and ‘penetration’ by the needle, an external object, moving into the interior of the body and extracting blood. In contrast to the relative ease and painless provision of urine samples, blood tests can thus be particularly negative bodily experiences. During Esther’s visits to the EPU, she had nearly double-figures of blood tests taken in quick succession, leading her

to feel like “a pin cushion”. A sense of vacated agency, whereby one comes to see their body as a physical object, was reiterated by other participants also. With years of medical tests and recurrent miscarriages, Caroline perceived her body as an object which medical staff were entitled to prick, poke, probe, measure and detachedly discuss between themselves: “I got really, really tired of it and just felt like this [body] is anybody’s but mine, that this is just not me, this part of my body has been taken over by scanning, prods and dyes, and the blood tests and oh god, it was just never ending”. Many of the women spoke about medical-technologies and procedures as negating their bodily autonomy in attempting to gain insight into the functioning of the interiors of their bodies. Bodily disassociation/detachment emerged as a response to, but could also heighten, vulnerability with the separation of self from body as one was “passively being *done to*” (Martin 1987 p86 italics in original). This was exacerbated by lacking emotional support from medical staff who breached ‘normal’ circumstances of privacy by intervening in the interiors of the women’s physical bodies through medical instruments and approaches. As Caroline recounted, “in between all that you’ve no one to talk to. I used to go downstairs in the hospital and sit and cry and I thought I don’t know how much longer I can do this”.

Echoing Casper’s (1999) comments, many participants emphasised that they would be willing to put up with a great deal of physical pain and psychological upset from medical interventions, providing there would be a ‘happy’ end result. For instance, in relation to the iatrogenic side-effects of fertility medication Clomid and the symptoms of pregnancy which share similarities such as nausea and breast tenderness, Esther explained how she saw the latter suffering as invested with hope and therefore made tolerable:

there was finally a point to them [side-effects, symptoms] – there was, there was a positive [pregnancy result]. So before everything went wrong with it, I’d always said to myself I didn’t... CARE if I had the worst pregnancy in the world so long as at the end of it there was a healthy baby, so I didn’t care if I was going to be sick or I was going to be, I don’t know, having headaches or fat ankles or whatever else came with it as long as there’s a healthy baby at the end of the day. I always said to myself I would never moan about being pregnant so as far as I was concerned, I felt sick and

this that and the other but there was going to be a positive outcome to it, so it was worth it.

However, faced with pregnancy losses and medical complications, including the removal of fallopian tubes following ectopic pregnancies or otherwise hampered fertility diagnoses, many participants experienced diminished and/or lost hope of having a (biologically own) living infant. This was particularly the case for those who had undergone long, arduous infertility treatments or whose relationship circumstances presented additional difficulties (see Peel and Cain 2012 on conceiving in lesbian relationships). When the ‘promise’ of a much-wanted pregnancy and, fundamentally, delivery of a living child is compromised or removed, the physical pain of procedures, tests, examinations and so on can become experiences of suffering without recompense.¹⁹ In light of subsequent ‘promising’ pregnancies, some participants’ experiences of the physical endurance of pregnancy loss retrospectively acquired new significances. For instance, 26 weeks pregnant at the time, Holly suggested that her naturally-managed miscarriage may, to some degree, prepare her for the level of pain and blood loss pre-empted in the forthcoming birth:

I think I’ll be better able to cope with the labour and {laughs} I don’t know how naïve I am, that I can handle the pain {laughs} but in my head it’s kind of, I got through that and so this is a positive thing, this means that I’ll get a baby at the end of this.

Hence, the anticipated outcome—contrasting the reward of a living baby with the grief of a pregnancy loss—is a key and highly emotional factor shaping how

¹⁹ Scarry (1985) argues that intense physical pain is a ‘world-destroying’, isolating experience which perpetuates and amplifies vulnerability. Refuting a clear separation between physical and emotional pain (see Bendelow and Williams 1995), Harrison (2002 p594) articulates how “[s]uffering does not have a limit; like an event which does not concern you it continues regardless of the point where you can no longer go on”. This is relevant for understanding some of my research participants’ experiences. For instance, Gemma commented about the use of medical pain-relief allowing some disengagement: “[a termination delivery is] very different to a live birth because [in the latter] you wanna be as there as possible, you don’t want to have lots of drugs”. In contrast to seeking “a sense of wholeness” with “the functional integration of all of a woman’s parts – her memories of the past, hopes for the future, her mind and body” (Martin 1987 p158) in *live* births, biomedicine can enable detachment of body and self, offering psychological cushioning in the case of such a traumatic scenario as for Gemma.

participants viewed their involvements with medicine. This, as will be discussed in the next section, was pertinently the case in relation to ultrasonography also.

Ultrasonography Spaces and Accompanying Waiting Rooms

External ultrasound, with a transducer moved over the stretched skin of a pregnant woman's abdomen, is an example of a technology "of the visible that reveal women's bodies to others and to themselves" (Weiss 1999 p124). In contrast to transvaginal probe ultrasonography, this form of 'accessing' the interior through the external skin/bump was most widely experienced by the women spoken to, including Caroline who had also experienced the former. Abdominal ultrasound images are salient in the popular contemporary Western imaginary of pregnancy (Matthews and Wexler 2000). Produced through the emission of electrical pulses to assemble a digital image from returned sound waves of the embryo/foetus in utero, ultrasonography images are medical representations with diagnostic and treatment purposes, yet they are also attributed powerful socio-emotional meanings. Many feminist scholars have highlighted the non-neutrality of ultrasonography, related imagery and the emotive discourses which circulate well beyond medical settings and agendas, including for pro-life/anti-abortion purposes in the public domain. In addition to termination, I argue that we need to also reflect on the ways ultrasonography features in other kinds of pregnancy loss experiences and in relation to the prevalent norms and values in which wanted pregnancies are deemed joyful/happy (Layne 2003a, 2003b) and linear trajectories of birth to death.

Ultrasonography is often associated with intensely emotional connotations of hope, anticipation and excitement, pertaining to, as Penny summarised, the fact that "[yo]u just presume you[r] going to have a healthy pregnancy".²⁰ Ultrasonography rooms and their accompanying waiting places are medical, diagnostic and treatment spaces which retain and facilitate links to a particular set of normative notions around pregnancy as the beginning, not end, of 'life' and medical heraldry. Rothman (2007c p50) argues that "[f]rom the grey blur on the ultrasound image, a fully formed fetus is read into being", with sonographers participating in constructing foetal personhood through

²⁰ As with urine- and blood- pregnancy tests, we might add that this is the case in 'expected' and/or 'wanted' pregnancies but in other scenarios ultrasound practices and imageries are clearly not benevolently experienced given their complex relations to termination politics.

‘showing’ and ‘baby-ising’ (Mitchell 2001). Narrations about ‘waving’ and ‘thumb-sucking’ ‘babies’ are therefore produced in the ultrasonography room, and in non-medical others’ responses to viewing the resultant images/videos, “with or without the participation of the mother” (Rothman 2007c p50). Yet women can find their ‘baby’ “quickly de/reconstructed as a “fetus” or even a “genetic mistake”” with the diagnosis of foetal anomalies (Rothman 2007c p50) and, I add, in other forms of pregnancy losses such as missed miscarriages.

For many persons, ultrasonography—as a practice and the concomitant images—appears to be largely divorced from the fundamental ‘monitoring’ medical roles (Petchesky 1987; Hartouni 1997; Jutel 2011; Peel and Cain 2012). Ultrasounds tend to be perceived in particular emotional-affective terms as opportunities to ‘meet’, ‘bond with’ and ‘see’ their ‘babies’ (Rothman 2007a, 2007c), including attempts to determine foetal sex for ‘gendered bonding’ (Larkin 2006). Constituting one of multiple foetal anomaly detection tests available to pregnant women in affluent Western contexts (Rothman 1994), actual experiences of ultrasonography can be ambivalent, fraught or deeply distressing. This was the case for a significant number of participants in the research, either recognisably at the time or retrospectively so. For instance, Caroline explained how, excited about the prospect of ‘seeing’ the baby for the first time, she attended a routine ultrasonography scan at 12.5 weeks:

[I] had gone up [to the hospital] with my youngest child who was three [years old] then and a couple of family members to come with me because, you know, it was like a day out really and [then] to be told the baby had died so it was [...] a huge shock.

‘Shock’ denotes a feeling of vulnerability as one experiences the impact of external conditions which can be neither understood nor accepted in the moment (Seltzer 1998). With Caroline’s first miscarriage of four diagnosed as a ‘missed miscarriage’, the actuality of the encounter in this medical space starkly contrasted to her (and her family members) expectations. Within this setting, ‘normal’ linear trajectories of time and pregnancy progression were sharply and suddenly ruptured, leaving Caroline overwhelmed and, at “the lowest point” following a second miscarriage detected in a similar manner, even suicidal.

Across participants, ultrasonography rooms were visited for different reasons, at various times, and subsequently resulted in diverse encounters. This included attending ultrasounds: as part of the routine tests for ‘normal’ pregnancies; as an additional service for women who had had previous pregnancy losses; if particular symptoms emerged, such as bleeding or pain, or disappeared, such as the cessation of morning sickness; and to check that there was no remaining ‘conception material’ which risked infection or other complications. Especially for women who have previously had very early pregnancy losses, ultrasonography scans can be important milestones relating to their psychological and emotional approaches to subsequent ‘tentative’ pregnancies (Rothman 1994). As such, these occasions were sometimes reassuring of foetal health and development, offering opportunities to ‘see’ the ‘baby’ with scan images to circulate between family and friends. If pregnancy losses later occurred in these pregnancies, the images sometimes retained or acquired great significance and value (see Chapter 8). However, as noted, scans were not unanimously ‘happy’ or ‘promising’, and could instead be highly traumatic occasions of learning that pregnancies had or would/might have ‘unhappy endings’ (Layne 2003b), including with termination as an option with diagnosed foetal anomalies (Ginsburg and Rapp 1999; Williams 2006).²¹

Rather than always involving the ‘joyful’ beginnings of life or pre-life, ultrasonography rooms can be spaces of intrauterine death. On such occasions, ‘death’ or otherwise cessation of ‘another’ (or potential other) within one’s body is encountered *through* the ultrasound scan screen and operating technician. These specific experiences can be considered as ‘out-of-place’ and ‘out-of-time’, linking to ideas also utilised by Convery *et al* (2005) in the emotional geographies of livestock slaughter during the 2001 Cumbrian foot and mouth disease outbreak. In this latter context, the death of many (pregnant) ewes occurred at the wrong place, in the farm rather than abattoir, and at the wrong time in the farm calendar and life cycle of lambing (Convery *et al* 2005). In relation to my research, the loss of wanted pregnancies can be understood to occur in the wrong place, the ultrasound room, and at the wrong time in terms of being before (postpartum) ‘life’. Whilst the vocabulary of death and dying in

²¹ Missed miscarriages—in which the pregnancy has ended but not been reabsorbed or expelled with uterine bleeding—are only detectable through ultrasonography technology and thus this diagnosis *depends* on the contemporary availability of ultrasonography (Peel and Cain 2012).

relation to embryos/foetuses is not without concern nor is it used by all individuals who experience pregnancy losses (Kevin 2011), acknowledging that some do has important implications for burgeoning areas of scholarship such as the geographies of death and dying. The topic of encountering the blood and other materials of ended pregnancies will be discussed further in Chapter 5.

Other emotional responses to unexpected and unpleasant circumstances of ultrasounds included sadness regarding the shattered expectations about ultrasonography as a happy, rites of passage life event. Aware that she was pregnant for the first time shortly before the onset of heavy uterine bleeding, Lara's first experience of ultrasonography was following a visit to Accident and Emergency (A&E) in order to check if the miscarriage had been 'complete':

I found it really... I don't know, a bit intrusive, it wasn't the experience that I imagined in my head, obviously I thought the first time I'd have an ultrasound that I'd be so happy to see my baby inside like moving or whatever and then it turned out the first time around was to check that it was gone.

The circumstances of Lara's pregnancy, as well as this first experience of uterine ultrasound, departed significantly from what she had imagined for herself in terms of biologically having children when she was older and in a stable marriage. As Zucker (1999 p783) highlights, women who become pregnant unintentionally "may experience feelings of failure at controlling their reproductive lives [rather than, or in addition to, such feelings being caused by the event of ended pregnancy itself]". Women may be in the process of reconciling their expectant 'mother' identity and forthcoming roles, or only recently come to terms with this, before disruption by pregnancy loss (Price 2008). Thus there are multiple components coalescing in experiences such as Lara's, with various points of disjuncture between imagined reproductive future/hopes, belief in self-mastery regarding this and the actual situations experienced.

The emotional geographies of ultrasonography spaces and interactions are complex, concerning medical 'situations' such as anembryonic miscarriage, foetal death and anomalies which contrast sharply with hopes and expectation for wanted pregnancies. Other aspects of these medical settings include: staff

demeanour, in terms of tone, conversation content and body language; the built and adorned environment, with details like chairs, posters and magazines; the practicalities of service provision such as scan availability over weekends and bank holidays; and the multiple socio-symbolic messages of value which these can be read as conveying. The material, symbolic and social dimensions of ultrasound spaces can have important consequences for those who experience pregnancy losses, impacting on emotional encounters as recalled in interviews. Participants recounted different material resources in ultrasonography provisions, as well as various social interactions with staff (medical, administrative) and other patients/visitors. Alongside variable availabilities, locations, opening hours and services of ultrasonography including of/at EPU (McLean and Flynn 2012; National Institute for Health and Care Excellence 2012), participants suggested that the physical constitutions of such spaces could convey particular meanings about the sociocultural marginality of, for instance, threatened or suspected miscarriages.

Returning to the example mentioned earlier, Esther enquired about why her GP's scan request was rejected: "when I asked why, why not – it was 'we haven't got anyone to do one, we haven't got the time'". Following the message that Esther/her pregnancy was not a top priority for the medical staff, blood tests were taken instead. Abruptly informed that her pregnancy had ended but with no onset of uterine bleeding, Esther was finally offered an ultrasonography scan several days later. Numerous components of this eventual ultrasound experience were distressing, including the demeanour of the staff and their habitual practices of showing visual outcomes, rather than turning the screen away, despite knowing the image would likely be of foetal death: "there was no thought, there was no compassion, there was no empathy for the fact that I might not want to see what she was going to see on that screen". An additional factor involved other patients since:

[the EPU] waiting room is the same waiting room where couples are coming in and out, having, you know, good scans, successful scans [...] happy occurrences erm... there was very little sensitivity to separate people from each other [...] in the sense that, you know, if you're grieving a miscarriage, the last thing you want is

the couple opposite you to be cooing and all excited over a scan picture in their hands.

Esther, having spent a significant amount of time in this waiting room, was acutely aware of the material constitution of the space. She described it as:

very VERY... I want to use the word grubby [...] I remember the walls were a sort of dirty yellow colour that BADLY needed refreshing and there was no, in that waiting room, there was no literature on the walls, there was a box of toys in the corner and like a coffee table covered in old tatty looking magazines [...] it was very... soulless [...] and it was a very uncomfortable room to be in.

Esther's comments suggest that such waiting room spaces can compound upset about pregnancy loss through the aesthetics of décor and provisions, especially when occupied over a protracted portion of time awaiting a conclusion on whether a wanted pregnancy had ended. Such dismal and tired spaces convey a lack of consideration for those waiting in such circumstances and can foreground the deprioritised place pregnancy losses are attributed in the wider social (as well as medical) context.

The experience of an ultrasonographer "seeing something unexpected on the screen" (Rothman 2007c p51) can set in motion a series of incoming staff and their exchanges. During a routine scan in Penny's third pregnancy, a foetal heartbeat could not be found. At this point:

[the ultrasonography technician] said she will [get] someone else to check and went out the room[.] [I] turned to my husband and told him then '[I] think the baby has died'. Then the lady [technician] c[a]me back with someone else and she [second person] looked again at the screen and did another scan and she confirmed that my baby had died and she just got back up and left. Meanwhile the other lady [technician] just kept saying sorry and gave us 5 minutes then came back in and told us to wait in another room next door. I just felt like [I] was being shoved into a room without any thought or explanation at all[.]

Drawing from Edvardsson *et al* (2003) on narratives of distressing ward atmospheres, the social dimensions of this medical situation entailed Penny ‘experiencing chaos’ and ‘not being seen’. The relative lack of engagement with Penny from the second member of medical staff, who instead focused on the screen, can be seen as pertaining to ultrasound facilitating thinking “of fetuses [and embryos] as separate patients more or less trapped within the maternal environment [...] The woman is erased, an empty surround in which the fetus floats” (Rothman 2007c p49). Indeed, the location of the foetus is technologically displaced from inside the woman’s physical body to a distanced screen, making it possible to ‘look’ at the real-time interior uterus with one’s back physically turned to that very pregnant woman. This echoes with Martin’s (1987 p146) comments regarding foetal heart monitors as also having “the effect of removing the mother”. Whilst the negation of one’s own embodiment may be accepted or overlooked in pursuit of ‘healthy’ and ‘happy’ pregnancies, it can be additionally upsetting and confusing when pregnancy losses occur, potentially prompting the kinds of bodily detachment previously discussed.

Thinking through the socio-political implications of such technology, Taylor (2004a) ‘maps’ some of the many locales at which ultrasound images become visible, including car advertisements. Feminists have criticised the co-option of foetal-centric discourses and visual imagery for anti-abortion purposes, expressing concerns about the prolific use of ultrasound and the presence of subsequent images widely dispersed in society (Petchesky 1987; Hartouni 1998; Casper 1999; Michaels and Morgan 1999; Stabile 1999; Fox 2000; Woliver 2002; Taylor 2004a; Kevin 2011). An additional consideration I have concerns the impact of distributed scan imagery on some women who have experienced various pregnancy losses. Some women whose pregnancy losses were diagnosed with ultrasonography had subsequently encountered its visual and auditory presence. With the diagnosis of intrauterine death, Isabel recalled how “[s]eeing the picture of our little baby on the [ultrasound] screen still haunts me. I still shudder every time I see a scan picture”.

Aspects of ultrasonography experiences can spatially and temporally ‘travel’ – emerging abruptly, disrupting expectations of futures and ‘haunting’ those “who are enjoined to publicly gloss over the loss[es]” (Peel and Cain p87). Isabel had since encountered ultrasonography beyond the medical sphere in

numerous locations and scenarios – sometimes anticipated, like in television shows like *One Born Every Minute*, but also in unexpected locales. This included: in her home/living room with the aforementioned maternity ward show and in nappy advertisements; online social network sites via others profile pictures and posts; outside churches, with Christmas posters depicting scan images of ‘baby Jesus’; and in café-restaurants when another person played a foetal heartbeat sound clip. This latter aspect highlights that it is not only visual sights but also sounds which can trigger emotional responses. Komaromy (2000) makes such an observation in her research whereby the sounds of death include squeaking trolley wheels in residential and nursing homes. For Isabel, hearing a foetal heartbeat sound clip at a later date can be understood to reiterate the disjuncture between her expectations and the deeply distressing scenario of silence. In the following section, I turn to consider some of the interior sensations (feelings, touch) involved in pregnancy and pregnancy loss which have arguably been displaced by the proliferation of ultrasound (Duden 1993).

Self-knowledges and Intra-body Touch

Medical-technological ‘access’ into the pregnant body produces “the foetus as a subject at the expense of the pregnant woman’s own visibility” (Tyler 2001 p78), allowing the overlooking and denigration of pregnant women’s self- or embodied-knowledges. Ultrasonography then enables the (re)presenting of foetuses to a vast array of persons, sometimes without the pregnant woman’s knowledge/consent (Duden 1993), including multiple medical staff, partners, family and friends with the Internet/email allowing quick and potentially unfettered circulation of ultrasonography images. Embodied sensations of foetal presence such as quickening, the feeling of foetal movement, have been delegitimised and disembodied by the proliferating use of such technology, since the pregnant woman relinquishes at least some control of ‘knowing’ and ‘perceiving’ her own pregnancy and its involved changes/processes (Duden 1993, 1999; Stabile 1998). The intimate experience of internally feeling a foetal kick or twist is detracted from by medical-technological abilities to externally represent, such as through ultrasonography, as are the relational sharing of such sensations which may be perceptible to others later in pregnancy development with the knowledge of where to place a hand preferably remaining with the

pregnant woman. It is also significant that the production of an external representation of this interior space of the uterus, normally considered private and personal, occurs in semi-public institutional settings of medical spaces, occupied by otherwise unknown medical staff, and the images are then often circulated.

The scientific ability to ‘picture’ the foetus in utero, alongside the wide cultural dispersal of images such as Nilsson’s 1965 *Life* photographs, has underpinned discourses attributing ‘foetal independence’ (Petchesky 1987; Hartouni 1998; Stabile 1998; Michaels 1999; Tyler 2001; Draper 2002a). Within this, the foetus assumes a free floating “discrete and separate entity, outside of, unconnected to and, by virtue of its ostensible or visual independence, in an adversarial relationship with the body and life upon which it is nevertheless inextricably dependent” (Hartouni 1998 p213). Subsequently, “[a]s fetuses in their “maternal environment” become ubiquitous, women seem to vanish” (Michaels and Morgan 1999 p4). However, speaking of the nude pregnant Demi Moore on the 1991 *Vanity Fair* cover, Tyler (2001) argues that other visual representations are possible, such as those foregrounding the pregnant woman and her external skin (also Matthews and Wexler 2000). In addition, the theme of ‘touch’ can prompt a rethink of hierarchised senses in which vision has dominated, including within geography (Paterson *et al* 2012), in order to challenge the ways that ‘maternal space’ is effaced by the notion of the alone foetus occupying the ‘uterine environment’. Indeed, some participants conveyed a sense of the emotional value of embodied movement as supplementary or even advantageously over ultrasonography. Helen, having had a miscarriage previously, spoke of her two subsequent successful pregnancies:

[b]eing able to feel the baby move was also another significant milestone – it made it even more real – a scan shows you that there is a baby developing in there, and that's amazing – but not the same as being able to feel that baby inside you – both as a bump and through movement.

Such felt movements—which are simultaneously interior to, and yet always a part of one’s, fleshy self—offer a particular way of ‘knowing’ pregnancy which resonates, I argue, with Tyler’s (2001 p81) calls to “re-envelop[e] the foetus within the pregnant body”.

‘Embodied’/‘self’ knowledges of lived experience can contrast with, and potentially critique, biomedical understandings of the body as a mechanical object. In the medical model, bodies are monopolised by a focus on biological functioning. Measurable, quantifiable changes are seen as particularly relevant, such as hCG levels in the blood and ultrasonography showing size/development of the foetus, and are primarily interpreted in relation to the teachings of physiology and anatomy. Particular bodily dimensions such as amenorrhoea and breast tenderness are deemed relatively reliable ‘indicators’ for medical consideration, whilst other ways of ‘knowing’ or ‘feeling’ can be altogether overlooked or discounted as irrelevant or inadequate. Thus social meanings and understandings attached to such bodily experiences may be recognised to a limited degree in medical practice, such as social bonding in ultrasonography, but are not the primary interests/purposes as focus remains on ‘objectivity’ rather than the ‘subjective’ experiences. Dimensions ‘other’ to biomedical functioning, like notions of social parenthood and thus ‘parental bereavement’ (Murphy 2012a, 2012b), can be systematically refuted in medical practice. For instance, Anne recounted the hurtful language used by medical staff which conveyed a sense of her stillborn son “like he was a bit of meat that was going off”. Foregrounding the complex interconnections between materiality, social meanings, subjectivities and emotions offers an alternative approach, critiquing the dominance of medical/medical-technological engagements with/in human bodies which, Sobchack (1998) argues, can be highly disempowering.

The concept of intra-body touch can highlight that bodies involve constant, dynamic corporeal contact with themselves (Colls 2012). In the context of pregnancy, this can displace prevalent biomedical understandings, now socially very potent, of a separate foetal entity merely in the ‘vessel’ of a pregnant body. Rather, the situation is far more complex:

[t]he pregnant woman’s external skin is the boundary between herself, as a discrete being, and the world. Within this external skin, there is a membrane or skin sac within which the foetus floats [in amniotic fluid]. The membrane that coats the foetal body is both part of her skin and the skin of an other who is not yet a separate self. It is very difficult to distinguish between her skin

and the foetal skin while the foetus is alive; the pregnant woman experiences the foetal skin as part of her-self (Tyler 2001 p80).

Additionally, it is not until two weeks after conception that the cells of the embryo and placenta differentiate (Franklin 1991, 1999). The placenta, attached to, and vital for, sustenance of the foetus, is thus a mediating organ constantly connecting multiple maternal and foetal tissues. In subverting the immunological defences of a pregnant woman, the placenta refutes the notion of a discrete foetal being simply occupying the ‘inside’ cavity of the uterus. It is pertinent that Nilsson’s iconic and influential images of ‘free floating’ foetuses omit (Tyler 2001) or only partially acknowledge (Stabile 1998) the placenta, embryonic sac and, indeed, uterus. Wolvier (2002) argues that our dominant cultural conceptions of pregnancy and birth are envisioned from a male perspective, citing Rothman (1989 p17) in saying:

[o]ur bodies grow out of the bodies that surround us [including those of our mothers]. We don’t, as our language would have us believe, ‘enter the world,’ or ‘arrive.’ From where? Women who give birth, I have often pointed out, don’t feel babies *arrive*. We feel them *leave*.

Hence, “[t]o say that women first hold their babies after they are born is to say that the nine-month experience of pregnancy was nothing” (Woliver 2002 p123). This is also relevant, I add, for the duration of any pregnancy and regardless of whether it cumulates in live birth/living infants. Ben recognised this tension in relation to the stillbirth of his niece:

I remember thinking we measure people’s age through their BIRTHDAYS, that’s why it’s called *birth* days [...] we don’t count any of their time in the stomach, yeah, and I remember then thinking well ‘this is at odds with my sister’s kind of philosophy’

Quickening—the felt foetal movements usually perceptible in the second trimester—prominently highlights pregnancy as a constant, inter-relational touch with sometimes intense, startling sensations.

Foetal movements were sometimes discussed in relation to the dual benefits and discontents of medical technologies. With her first pregnancy

successful and her second ending in miscarriage, Jane described anxiety during her third pregnancy which was ongoing at 26 weeks at the time of interview. Illustrating the pregnancy as ‘tentative’ (Rothman 1994), Jane said she had not “realised how stressed I was about the 12 week scan until after it had happened, and then the sense of relief was enormous”, adding that “luckily I started feeling the baby move quite early, before 16 weeks[,] which was extremely reassuring”. In an attempt to augment the sanctioned medical knowledges from routine check-ups and ultrasonography scans, Jane bought a hand-held doppler for home use to assess foetal blood flow and thus heartbeat:

[buying a doppler is] something I said I would never do, and I have actually talked friends out of buying one in the past as I understand the risk of hearing your own heartbeat and thinking the baby is fine.

When I asked Jane further about reconciling her decision, she explained her concerns were abated with the advantages of her healthcare professional knowledge on how to use and interpret the machine effectively.²² The doppler permitted benefits for Jane, such as allowing anytime assessment of foetal heartbeat and the opportunities to “share the experience” with her husband and son. She found there was often an unexpected result in that “listening in with the dopplar makes her [the foetus/baby] move around a lot, which tends to alleviate any worries before I even find her heartbeat!” Thus, whilst medical technologies like dopplers can yield auditory evidence of a current foetal heartbeat, internal movements can too be highly informative, in a quick and obvious fashion. In addition to the doppler *prompted* foetal movements, Jane had an extensive knowledge about these in relation to time of day and scenario:

I know she doesn't move a lot in the mornings. [My son] still has an afternoon nap where I can put my feet up for a while, and she usually has a little kickaround then which reassures me. I can make her move by laying down and cupping my belly with my hands, or by drinking something cold which I do before getting the

²² As Jane explained, it can be difficult to locate the foetal heartbeat so that she knew that if she could not, it “wouldn’t be an immediate worry”. She also recognised the need to take her own pulse before use to be sure that the doppler is not only returning the maternal heartbeat.

dopplar out. She also responds a lot to [my husband] talking to her or putting his hands on my belly [...] and when [my son] cries.

These sensations were prolifically experienced yet ambivalently described: “I didn't think it was a particularly nice feeling”. Additionally, Jane spoke about impressions from within visible on the bump/skin; she explained how “[l]ast night in the bath I could actually see my stomach move for the first time and it was so reassuring to actually see something physical and know she's okay”.

The respective pregnancies discussed in this section regarding Jane and Helen culminated in live births but were impacted or recollected in ways influenced by previous miscarriages. Internal foetal movements were also spoken about by participants who had experienced these during pregnancies which later ended in loss/death. This included the highly distressing experience of felt internal movements during pregnancies that one had been told had ended or would soon be ending. For instance, following a reassuring 12 week scan, Gemma described her enjoyment of feeling foetal movements alongside reading pregnancy books during her first pregnancy:

[p]articularly as the pregnancy progressed and the descriptions of developmental stages became more exciting, as we became closer to that stage at which you know the pregnancy could be viable if it was to end early, as the baby started to move; more and more we were at the point of obsessive[ness] about the whole thing - what it was doing, what we would call it, what we needed to buy.

However, spina bifida was diagnosed at the 20 week scan and the difficult decision was made to have a termination. Gemma spoke about the medical process of preparing her body for delivery several days later and requesting an injection to conclusively end the pregnancy and thus foetal movements:

what you have to do is you take some kind of medication that prepares your body for labour {sigh} ‘cos obviously it's not a natural, to be induced erm and I also had an injection which was kind of a lethal injection into the baby's heart so at that point, at that moment in time that day, the baby wasn't alive anymore. So all the moving and the stuff... stopped [...] which was something that I had pushed, consciously pushed for. Erm and then I think it

is kind of two or three days you have to carry the... foetus... erm before you can deliver because your body needs that time to prepare to deliver the baby.

In asking for the injection, as it was not offered and was only reluctantly provided, Gemma suggested that the prompt cessation of foetal life was an important but nonetheless upsetting component to accepting that her pregnancy would end:

if you imagine you've taken a drug which means that that pregnancy is definitely no longer viable but you can still feel your baby [...] moving and what happens if you then change your mind, you know, it's too late, it's already happened, so I kind of wanted to know that it had already happened and have no ambiguity about that, I guess [...] it was to protect myself basically.

Without the injection, Gemma thought the foetal movements would further amplify the distress around deciding to terminate which, with the medication to induce such premature delivery, was already occurring. The doctor's reluctance towards the injection highlights possible emotional impacts on medical practitioners carrying out such procedures (Chiappetta-Swanson 2005; Williams 2006; Ludlow 2008). Whilst some people may have found this frustrating or additionally burdensome, Gemma implied that seeing the doctor's emotional response was in some ways valuable in validating that her experiences were distressing: "I kind of respect the fact that he found that a difficult process to be involved in. Erm if he, if he'd sort of taken it lightly or been flippant about it then that wouldn't of, I wouldn't of appreciated that".

With diagnosed intrauterine death, potential felt interior sensations can be disturbing, abject and confusing. Isabel's second miscarriage was diagnosed at the 20 week anomaly scan when a foetal heartbeat could not be found. As mentioned, the ultrasound image featured prominently in Isabel's memory:

I remember lying on the bed and just bursting into tears after she told us she could not find a heartbeat. She left the screen showing the baby directly in front of us and I could not take my eyes off the screen, wishing everything was ok.

In the time between taking the medication to induce labour and the delivery a few days later, Isabel became particularly anxious about internal sensations since, if these were foetal movements, then the diagnosis of foetal death would be incorrect. Isabel talked to her sister-in-law, who had been a nurse as well as having previously experienced multiple miscarriages and stillbirths, the evening before going into hospital to deliver:

I was on the phone to [her] for a long time talking about how I thought I still felt movements and although the doctors were telling me that I had to go in and have the baby, I really did not want to because I found it really hard to believe there was something wrong (most probably wishful thinking on my part and being anxious about the next day).

Isabel's sister-in-law suggested that "it most probably [wa]sn't the baby moving, it's just erm... just my internal organs and just sort of liquid in my body". Isabel spoke to a nurse the following morning and was offered an ultrasonography scan to "put my mind at rest and just to confirm that what they said was actually true". Although she declined the scan, as the medication to induce delivery had already been taken, the offer was reassuring and bolstered her confidence that the medical staff "knew what they were talking about". Whilst nonetheless an upsetting experience, with Isabel's internal sensations and enduring hope juxtaposed to the medical diagnosis, the reassurances provided by her sister-in-law and the nurses seen on the day of her delivery were greatly appreciated.

Elusive Sensations, Memory and Affect

Whilst many of the women drew on biomedically-affirmed knowledges, such as urine and blood- tests and/or, depending on the stage of pregnancy, perceptible 'intrabody touch' (Colls 2012) like internal foetal movement – several participants also spoke of other kinds of interior feelings and sensations. This included, with a degree of hesitancy, sensorial attunements which were not externally or medically evidenced at the time. For instance, Jane described having had "gut instinct" that something was wrong early on in a pregnancy, leading her to request an earlier scan which her GP declined. As the pregnancy progressed, Jane put aside some doubts as she perceived bodily changes deemed reassuringly 'normal' within pregnancy. On diagnosis of anembryonic

pregnancy, Jane questioned her bodily experiences of having felt physiologically, progressively pregnant in disjuncture with the outcome. Being told by medical staff that her pregnancy bump had been hormonal rather than physiological had been especially upsetting as this had been:

one of only a few things that made me 'feel' pregnant at the time, apart from the lack of periods and the nausea. I remember saying to the nurse practitioner at the EPU that I still felt pregnant because of these things, and she said it was all down to strong hormones, but she didn't say more than that. Maybe I did imagine that I had a bump, but enough people commented on it to make me believe now that I did at the time.

A few other participants also spoke about feelings and perceptions which did not yield an obvious explanatory biomedical elaboration; lacking validation as a source of 'knowing', these potentially highly emotive sensorial experiences were often dismissed by others. For instance, Jane's GP had previously "said [that] they didn't offer anyone earlier scans unless circumstances were exceptional, and to go home and stop worrying". Given that a biomedical approach is likely to deem as unreliable a pregnant woman's 'sense' that she was, for instance, miscarrying in the absence of sanctioned biomedical symptoms like uterine bleeding, such feelings were particularly difficult to convey and interpret.

Linking to this is the culturally-prevalent scepticism towards alternative 'holistic' approaches of complementary and alternative medicines like acupuncture (Gatrell 2002). Practices such as yoga and acupuncture, "based as they are on concepts of the body not recognized by Western science, have occupied an ambiguous position in Western culture. They are not quite denounced as superstitious, yet not quite accepted as efficacious" (Classen 2005 p348). Isabel attended an acupuncturist initially for a different health issue which had not responded to biomedical treatment; in trying to conceive in her third pregnancy, she had taken vitamins and used ovulation kits as her cycle was irregular, but "in the end, I went for acupuncture again and that – I'm sure that's what did it". Isabel explained the logic as the acupuncturist had told her: "different parts of the body control different organs and things like that and so he was saying about erm the amount of heat and cold in the body [being important]". From a Western biomedical perspective, using suction cups and

lamps to introduce more 'heat' into a person's body in order to prompt regular menstrual/ovulation cycles is likely to be treated with suspicion in tension with biomedical understandings of the physiological body (Classen 2005).

Sensations—ever-escaping external classification or firm grasp (Benthien 2002)—can defy verbalisation or easy accommodation to particular logics of how the body functions. For instance, Victoria described having had a 'feeling' about her pregnancy which was later miscarried. Though she included details that might be deemed more fittingly biomedical in this, such as the absence of morning sickness and a lack of tiredness, she also implied something else was 'felt' that she could not neatly translate with, or into, medical interpretation:

I know this may sound odd but I just didn't 'feel right', there was this feeling all the time in my mind that something wasn't right. I just tried to ignore it and I put it down to the fact that I had a little one [infant] to look after and I had to carry on normal for him. But there was always this nagging feeling that something wasn't 'right'. I did not really get a chance to say anything to a dr because I miscarried before I had a chance to see a dr again. [...] Maybe it is woman's intuition?!

Victoria reiterated her comments when I encouraged elaboration on 'woman's intuition', emphasising that she was not alone in having this feeling. She drew on her friend's words whilst signalling the difficulty of expression: "[w]hen I spoke to my friend who miscarried [around the same time] she said she just didn't feel right and I think that is the best way to describe it". 'Intuition', Victoria implied, is a form of body-self knowledge which involves an involuntary attentiveness to one's bodily habitus as being unsettled in some additional way:

[a]lthough it is not nice to feel sick constantly and tired [during pregnancy], they are signs that your body is busy doing something so to not feel any different, felt wrong as if your body isn't doing all it should be doing to help the pregnancy along. I think your body tells you when it is doing what it should be doing [and thus the contrary].

Drawing on her felt bodily memories of a past experience of successful pregnancy, Victoria implied that the different bodily feelings were registered on

some level of her body-consciousness as a sign that the (later miscarried) pregnancy was not developing in a sustainable way. It seems that remembered ‘dys-appearing’ bodies, such as those of previous pregnant embodiment, can echo and ricochet, potentially highlighting divergence from the subsequent embodiment of a (non-viable) pregnancy. Leder (1990) suggests that bodily processes tend to be backgrounded until events of ‘dysfunction’, such as physiological change, illness, and disorientation, at which point they ‘dys-appear’.²³ In other words, I am suggesting that some sensations—whether described as ‘gut feeling’, ‘intuition’ or more vaguely that something is not ‘right’—can be understood as entanglements between multiple emotions and temporalities (past memories and fears for the future) which are embodied and felt but may not be understood or validated by external others.

Relevant to this suggestion are the concepts of rememory (Hirsch 1994 and Prosser 2001, referring to Morrison’s 1988 novel *Beloved*) and postmemory (Hirsch 1997) in combination with trauma theory insights such as on belated and unassimilable temporality described by Caruth (1996). Meek (2010 p5) argues that “[t]rauma may not be consciously registered at the time of its occurrence but it returns in the form of intrusive memories, nightmares, compulsive acting-out and flash-backs” as well as resurfacing on the body (Takemoto 2001). Prosser (2001) suggests that rememory can highlight the ways in which additional cultural and historical layers are unearthed, even if/as they remain unconscious.²⁴ In the context of Morrison’s (1988) *Beloved*, Prosser (2001) argues that the scar of (returned) Beloved’s slit throat allows Sethe to work through the rememory of infanticide in the context of racial and gendered slavery. Subsequently, this narrative of maternal rememory demonstrates “how

²³ Leder (1990) argues that ‘healthy’ human beings background vital bodily processes and rhythms sustaining life, including breathing, heart-beating and digestion, in addition to engagements with familiar tools/objects. Moments of ‘dysfunction’ like illness or otherwise physiological change cause the ‘dys-appearance’ (bringing into awareness) of the body (Leder 1990). However, deeming pregnancy to be a ‘dysfunction’ chimes problematically with historic perceptions of the pregnant body as ‘ill’ in contrast to the ‘stable’ male body. Additionally, particular assumptions are embedded in Leder’s (1990) arguments as to for whom such activities privilege bodily backgrounding – thus overlooking different forms and fluctuations of embodied being (see Moss and Dyck 2002 on women with chronic illness).

²⁴ Morrison (1990 p205) argues that “the act of imagination is bound up with memory”, including in emotional and bodily ways, as utilised in the ‘texturising’ of ideas in her novels.

unspeakable memories might in fact be spoken, how a story that should not be passed on can in fact be transmitted” (Hirsch 1994 p109).

Postmemory denotes the possibility that memories and emotions can be partially transferred between persons, such as across family generations (Hirsch 1997). Tucker (2010) provides an example to show the partial presence and simultaneously concealment at work in ‘postmemory’. Tucker (2010) describes seeing a model fighter plane with a printed swastika symbol on the tailfin in a shop window. Faced with the dilemma of altogether destroying the object (a negation of history that would allude complete erasure) or displaying it (risking being seen as glorification of deeply traumatic experiences/legacies), the shop owner sought a balance by sticking a piece of masking tape partially over the swastika. Such a remnant, capable of stirring emotions and culturally-dispersed memories, even for those without direct experience, had a compromised existence as neither entirely concealed or erased nor fully visible. For Hirsch (1997 p22), postmemory is not the recollection of an individual’s own direct experiences but a generationally displaced memory form:

[p]ostmemory characterizes the experiences of those who grow up dominated by narratives that preceded their birth, whose own belated stories are evacuated by the stories of the previous generation shaped by traumatic events that can be neither understood nor recreated.

I argue that such a notion of postmemory is especially relevant here given that numerous participants, prompted by the event of their own pregnancy losses, learnt of other women in their families (their mothers, grandmothers, distant ancestors) who had also experienced miscarriages, stillbirths and neonatal deaths. Thus, it is possible that even if the events of traumatic pregnancy/infant loss are never verbalised by the parents, it may retain a presence (albeit inconclusively and perhaps unconsciously) in the lives of their offspring which—during their own reproductive experiences—can emerge (see also Kempson and Murdock 2010 on siblings never known). Such a possibility about transference might also help explain why the experience of some anxious or ambivalent sensations can be intense, inducing one to act yet evade firm grasp of meaning.

Perhaps precisely because of the slippery, unconscious processes at work – participants did not (could not?) describe their experiences in such psychoanalytical terms of transferring memories, emotions or affects from one person to another. However, as mentioned in the Methodology chapter, Parr *et al* (2005 p98) remind us that difficulties in attempts to articulate experiences should not silence or disregard “what situated individuals within these places *do* manage consciously to ‘say’ about what they think is occurring”. For instance, Holly found out during her miscarriage that her mother had also experienced several, though “it took her two days to tell me because she didn’t want to go through [remember] it herself again, she didn’t want to talk about it”. Later in the interview, Holly suggested that perhaps she had already known about her mother’s miscarriage prior to this, but that the timing (when Holly was a young infant) and quantity of losses (multiple rather than singular) were somewhat confounding. Holly expressed shock at the fuller discovery of her mother’s past of miscarriages which disrupted her previous memories and understandings of her parents, their shared family history, and even her childhood:

I thought it was before me... but it wasn’t, it was with my step-dad after me, so when I would have been about four [years old] and she had two [miscarriages] in a row and then they stopped trying because she was... she just said that she was worried it was something to do with their compatibility and she didn’t want to put herself through it.

Holly felt all the more anxious when her mother held back details: “she didn’t want to talk about it [miscarriages], but she could see that was the thing that was scaring me most, but so when she told me that was such a big relief that I knew what was going to happen and I didn’t need to be terrified about it”. Thus, postmemory of her mother’s losses, with distress both present and absent, may have played a part in how Holly experienced her own miscarriage.

There seems to be socially-encouraged ‘amnesia’ or censorship around the fact that there can only be provisional and limited reassurance of pregnancy outcomes, as Ginsburg and Rapp (1999) demonstrate in relation to prenatal testing. For me, this resonates with Layne’s (2003b) observations of pregnancy and women’s health books which tend to amass ‘exceptions’ *after* otherwise linear chapters on ‘normal’ pregnancies and births. By marginalising pregnancy

losses to the ends of such books, the attitude is conveyed that “[t]hose lucky ones whose babies survive, one infers, need not trouble themselves by reading about such unpleasant topics” (Layne 2003b p1887). For those who experience pregnancy losses, or know those who have, the belief that there is ever a ‘safe’ point at which anxiety can be vanquished is exposed as fallacy. Rothman’s (1994) account of ‘tentative pregnancies’ delineates a sense of pregnancy-as-precarious until (continual) reassurance of viability/development is given. The embodied sensation that something *is* or *could be* wrong can therefore be understood as relating to a realisation that is otherwise repressed in wider society, with the transfusion and movement of particular affects and emotions previously felt by oneself or another, such as that of sadness, vulnerability and fear for the future. Therefore, emotions and (post)memories can (re)surface sensorially in/as the body, across body-selves and stretches of time.

In some situations, the origins of anxiety regarding pregnancy are more traceably known. Gemma explained that she had been relatively unconcerned about foetal anomalies during her first pregnancy with no known family history of this and perceiving Down’s Syndrome as primarily applicable to later maternal ages, making it feel largely irrelevant to her. However, with memories from her childhood in which a close family friend experienced a stillbirth, her concerns concretised around the possibility of a similar occurrence. In addition, Siobhan’s involvement with her sister’s pregnancy, in which one baby of twins died postpartum, was reflected on regarding the implications for her own reproductive hopes and anticipated future. Given that the cause of neonatal death pertained to a recessive hereditary condition which Siobhan may also carry, this was an especially pertinent concern and one for which she was considering genetic counselling/screening in the near future. Describing her family as very “baby-orientated”, Siobhan explained:

I think I’ve always had a bit of a fear that I wouldn’t be able to have children or that something would be wrong with them and I think it has become even worse [...] the fact that I’ve seen babies be born and I’ve seen a baby die, that has really affected me, really affected and I think it WILL affect when it comes to me choosing to have children.

Subsequently, it seems that anxieties regarding pregnancy can be dispersed amongst persons in ways which range from largely known (as for Siobhan who recognised the impact of her sister's experiences on her own fears for a prospective family) to more unconsciously so (as may have been the case with Holly in relation to her mother's miscarriages, discussed also in Chapter 5).

Concluding Remarks

In exploring the theme of interior/internal bodies in pregnancy loss, I have considered understandings that are biomedical as well as more/other-than biomedical (sensation, movement, intra-body touch, intuitive feelings, postmemory). My consideration of ways of 'knowing' about pregnancy and pregnancy losses—such as urine and blood tests, ultrasonography, dopplers, felt movements and intuitive sensations—highlights participants' diverse emotional experiences. For instance, urine tests are 'domesticated' and now prolifically used in Western societies sooner/earlier during pregnancies, evoking excitement but also dread, reluctance and restraint. Whilst uncertainty about the materiality and processes of their interior reproductive bodies can invoke anxious 'tentative pregnancies' (Rothman 1994), seeking to counter this with biomedical practices of 'knowing' and intervening can also be highly emotionally and physically distressing, with potentially triggering consequences for subsequent reproductive experiences. The range of possible diagnostic outcomes from the medical-technology of ultrasound are often overlooked or overshadowed by prevalent cultural notions emphasising the practice and subsequent scan images as being about social 'bonding' (Peel and Cain 2012).

Participants' experiences of 'reproduction gone awry' (Jenkins and Inhorn 2003) counter cultural notions of pregnancies as always joyful (Layne 2003a, 2003b) and highlight the temporal, provisional and chemical precarity of some medically-sanctioned 'knowledge'. Biomedical, mechanical understandings tend to downplay other notions of the body and embodiment concerned with the interconnectivity of affect, emotion, sociality, materiality and subjectivity. A focus on the embryo/foetus as an independent being can background pregnant women which 'intra-body touch' (Colls 2012), in relation to pregnant embodiment, can counter. However, internal sensations can be highly valued as reassuring in some contexts but deeply disturbing during a pregnancy loss. Additionally, sensations of 'gut feeling' or 'intuition' featured in

some participants' narratives of pregnancy losses as denoting feelings which did not neatly fit with the biomedical approach. However, since these ambivalently or antagonistically sit with biomedical scientific logic and socially-sanctioned experiences, it seems participants were not able to elaborate extensively on these in the research. Whilst recognising the limits of attempts to linguistically represent such sensations, I suggest that possible understandings of these feelings include the reverberation of previous/remembered 'dys-appeared' bodies (Leder 1990) and the (re)surfacing of memories and emotions of familial others (Hirsch 1997) which are unintentionally 'transmitted' and embodied.

This chapter has considered bodily experiences entailing efforts to 'know' interior processes of pregnancy/pregnancy loss through particular bodily fluids externalised (urine, venous blood) or ceasing to be externally evident (menstrual bleeding, morning sickness), returned soundwaves producing visual or auditory representations (ultrasonography, doppler), and physiological changes read as signifying the occurrence (or not) of particular interior processes (pregnancy bumps). Felt movement and elusive sensations also highlight relationality since "touch lies at the interface between the perceived interiority of an embodied subject and the exteriority of the world they bring into existence through actions and relations" (Paterson *et al* 2012 p9-10). Further discussion of bodily experiences in the thesis will include Chapter 5 on bodily fluids/materials which cross interior-exterior bodily boundaries and Chapter 7 attending to the skin as an altering bodily exterior able to accommodate interior processes/matter, as indicated by a bump, potentially leaving visible marks and changed skin elasticity. This chapter has also included the presence and sometimes quite significant consequences of medical staff. Next, in Chapter 4, I will further consider the inter-personal context of pregnancy loss, involving familial and familiar social others.

Chapter 4: The Social and Inter-personal Context of Pregnancy Losses

Introduction

Pregnancy losses are heterogeneous experiences, involving different persons, spaces, emotions, sensations, practices, temporalities (past, futures, legacies) and materialities. Thus, ‘pregnancy loss’ cannot be said to denote a singular, universal experience or have a uniform essence – nor necessarily entail only one ‘individual’: the pregnant woman which, as Franklin (1991) points out, is actually always already more than ‘one’ body by virtue of pregnancy. Rather, at least for interviewees in this research, a myriad of different kinds of social actors in terms of individuals, groups, organisations and institutions participate in experiences of pregnancy loss in various ways. More than simply medical events, since bodies are both ‘private’ and constituted by social relationships, pregnancy losses entail “temporal and spatial dimensions” meaning that these “experiences change according to different social situations, times and places during a life course” (van der Sijpt 2010 p1775). In other words, pregnancies and pregnancy losses occur and are made meaningful (or not) in relation to the wider social world, history and projected future of each woman.

Taking a woman-centric approach in this research has meant foregrounding the voices and experiences of women discussing primarily their ‘own’ (biologically lived) pregnancy losses. However, their narratives also highlight a range of individuals who participated in shaping these experiences. Without foreclosing the scope of whom this might refer, examples relative to pregnancy-losing women in the research included: male partners or ex-partners (boyfriends, fiancés, husbands); male and female siblings; offspring (daughters, sons) and step-children; parents and step-parents; grandparents; family-in-law; friends (close, distant, of the family); and work colleagues. Researchers have called for, and directed attention to, persons characterised as often intimately but not directly/physiologically involved in pregnancy loss experiences, like male partners and siblings (Puddifoot and Johnson 1997; Worth 1997; Murphy 2009; Forhan 2010; Kempson and Murdock 2010; Hooghe *et al* 2012). Recognising this, I sought to also recruit such persons and subsequently interviewed one male partner (Graham), one female sibling (Siobhan) and one male sibling (Ben). In addition, those participants who were women with ‘direct

experience’ often spoke about the roles played by other social actors and occasionally passed on messages from their partners who were not officially participants in the research but had comments they wished to add.

This chapter will consider some examples of relationships and encounters involving persons beyond/other than women who have directly, physiologically experienced pregnancy loss. Whilst uptake of individuals who did not personally experience of embodied physiological pregnancy-losing was relatively low, those who did participate provided valuable and insightful contributions to the research. In this chapter, I will firstly consider Graham and Siobhan who had been involved in the care and support of pregnancy-losing women and were deeply affected by their experiences. This will involve reflecting on themes of socio-spatial marginalisation, grief hierarchies and care roles. In the second main part of the chapter, I will attend to the ways in which pregnancy loss entered into some work places and relations which were largely deemed ‘everyday’ and ‘mundane’ settings shared with familiar persons and ‘acquaintances’. With a focus on spaces of work/employment, I will explore a number of participants’ experiences of disclosure and communication about ‘events’ of, and ‘progress’ within, pregnancy and pregnancy loss.

‘Familial and Close Others’: Care Relationships

Categories of kin relations are not indicative of actual emotional or practical support, and judgements about socio-emotional proximity (‘close’ or ‘distant’) can be contested by different actors involved. Thus, I do not wish to impose a scalar template of presumed intimacy or quality of relationships since the diverse range of relationships exist which *between* and *across* families belie simplistic categorisation. Whilst some individuals had highly supportive partners and/or family members, other participants’ relationships with these persons were unhelpful, distressing and sometimes proliferated upset. Some people have ‘close’ relationships with their siblings whilst others do not and may be estranged. For some, ‘closeness’ designates practical support, whilst for others this may be more about emotional intimacy. As such, there is need to resist a hierarchy of relationships which relies upon categories based on position in a family structure with supposed implications as to proximity to events, emotional intimacy/impacts and subsequent roles.

The topic of social others also highlights home spaces which, for some participants, were preferable environments compared to that of medical settings.²⁵ For instance, cumulative medical experiences meant that Caroline opted not to go into hospital during her fourth miscarriage:

I know it sounds the bizarrest thing, but I thought ‘I’m not going to hospital. I’m clearly losing the baby, I’m losing a lot of blood and I’m not going to hospital. I’m going to do this on my own [at home] and I’m going to deal with it as I wanna deal with it’.

Caroline explained that this miscarriage “was the easiest one to deal with because I was in control” as opposed to “allowing someone [a doctor] to take from me what I hadn’t wanted taking away in the first place”. Some participants also described returning home after a medical procedure as preferable to remaining in hospital. For instance, after surgical management of a missed miscarriage in the morning, Natalie was able to leave the hospital in the afternoon. She found this:

really nice because you’ve been through something very upsetting, very traumatic but then can come home and be in your own space, in your own bed with your own family [including my two young sons] around you. If you want to talk – they’re there, and if you don’t want to talk – they’re still there.

For Natalie, being at home and surrounded by her family provided a familiar, emotionally supportive environment. Not only did this provide choices, to talk or just be together, but also granted her additional identity dimensions as a mother and wife, thus moving beyond being merely a patient/body.

The notion emerged in my research that medical staff and wider social others seemingly expected male partners to be central to offering/providing support whilst rendering their own needs for support peripheral. As Peel and Cain (2012) highlight, heterosexual norms are evident within much of the literature on pregnancy losses and this seems to be the case when considering

²⁵ Home spaces are not necessarily comfortable or supportive for all (Massey 1995; Mallett 2004), and can instead, or simultaneously, be sites of loneliness, fear such as about blood loss and indeed ostracism during pregnancy loss, including for women who are circumstantially alone in their accommodation at the time and/or are without supportive partners/family.

(monogamous) partners. Though aware of such a limitation, no participants in this research spoke of being in lesbian or polyamorous relationships; hence male partners will be the focus of discussion in this section since this most accurately reflects participants' experiences. The involvement of male partners is increasingly encouraged in pregnancies, from experiences of pregnancy test confirmation (Draper 2002b), ultrasound scans (Draper 2002a) to labour and birth events (Draper 2003). Yet they are often overlooked in relation to experiences of pregnancy loss (McCreight 2004; O'Leary and Thorwick 2006; Puddifoot and Johnson 1997). This may link to commonplace notions that male partners are less emotionally expressive (see Murphy 2009 for a comprehensive discussion of gender in relation to grief and mourning in stillbirth experiences).

Graham spoke in the research about his wife's 12 miscarriages in which he recounted occasions whereby he was physically excluded and emotionally marginalised in a number of ways. Graham explained that he and his wife had "been put through pretty much the entire range of well meaning, but insensitive help from the medical profession" as well as "some good examples of care, with compassion and wellbeing". However, a fairly consistent aspect, Graham noted, was that "[t]hroughout the entire process, a huge proportion of people have seen me as little more than furniture. Simple things like not having a chair for me during a consultation, or having the chair placed on the back wall out of the way". Graham elaborated on this in a subsequent email and, whilst adopting a joking tone at times, described the upsetting implications:

I'm pretty good at reading scans sideways on the angular limit for the screen these days ;-) [...] The overwhelming number of [medical staff] people that we saw barely spoke to me. I'd be stuck on a chair, away from my wife with the doctor talking directly to her and not involving me. I just felt uncomfortable, surplus to requirements and ignored.

These kinds of spatial arrangements and dynamics in medical encounters can therefore prompt further distress, making male partners feel marginalised and unwelcome, and have additional upsetting consequences. For example, Gemma described that her partner had been seated away from her in the room during a routine 20 week ultrasonography scan:

the [ultrasound scan] screen was directed towards me but away from my partner who was sitting some distance away in the corner of the room [...] I remember the image appearing as an open zip – the base [of the spine] had not fused together and the baby had spina bifida. I was in tears uncontrollably – [my partner] didn't really know what was going on, because he hadn't been involved in the conversation [owing to the seating arrangement].

Such problematic seating situations may stem from a lack of physical space in the room, including with cumbersome medical technologies potentially limiting available capacity and occupancy, or result from the preferred use and layout of the space by medical staff. Other seemingly minor aspects of buildings and signage could also convey attitudes of exclusion regarding male partners or male relatives and friends accompanying women who were pregnant or pregnancy-losing. For instance, Gemma recalled that her partner had:

made a comment actually, that we had to go up for a scan in [name of hospital] and there wasn't a male toilet in the unit and he was like 'WOW!' It's a really old place and it might of changed, or he might of missed it, but there was something like that, whereby he was like oh and it was kind of signage referred to like 'Women Wait Here'.

Whilst acknowledging that pregnancy-losing women are rightfully the focus of medical procedures and treatments if required, the dearth of offered emotional support resources is also revealing. Many of the women interviewed who had directly experienced pregnancy losses remarked that counselling services and information about support groups had often not been forthcoming from the medical staff encountered, verbally or in the form of informational leaflets. Though some of the women had looked into or attended professional counselling, often through referrals from later visits to their GPs, none of their male partners had been offered or been able to acquire similar support services. In this dominant approach, "[t]he feelings of the female partner are considered to be primary and legitimate, whereas those of the male partner are secondary and may easily be construed as extreme" (Puddifoot and Johnson 1997 p840). Graham explained that this was both a matter of professional services and

informal social support from friends and family, perhaps reflecting and reinforcing one another, in overlooking the fact that he might need support also:

[my wife] was offered counselling, I wasn't. In fact, I wasn't ever really offered much of anything. An occasional cup of tea was about the limit [in medical settings], and sometimes not even that. People in general seem very geared up to working with women, but nothing for men. That kind of includes family and friends too.

Seemingly entrenched, mutually exclusive expectations can stipulate who is seen to be a support provider and who a support receiver. There is little to no guidance on this, since “such male grief is rarely discussed, it is presumed not to exist” (Puddifoot and Johnson 1997 p844). As Puddifoot and Johnson (1997 p844) explain, “[i]f he were to openly discuss his feelings with his partner, it may be suggested to him, subtly or otherwise, that this will be upsetting for her, and that after all it is his role at this time to support rather than to grieve with his partner”. Graham spoke of an occasion in which he informed a member of management at work that he would need to take the day off since his wife had undergone an ERPC. The colleague proceeded to show Graham numerous baby photographs of his new-born grandchild. Whilst recognising that his colleague may have been unintentionally uncaring, Graham also acknowledged accountability: “I [am] fairly convinced that if you start off your sentence with “I know you won't want to see this, but” then you already know you shouldn't be wanting to do it”. This example demonstrates the ways familial and close others can be positioned as central to giving care whilst their own grief-work and needs for care are simultaneously negated and eclipsed. That is, Graham was acknowledged as a care-giver, provided the time off to attend to his wife, but not recognised as deserving of care or sensitivity himself, as implied through the inconsiderate behaviour of his colleague. Social groups can thus withhold, as well as grant, permission to grieve and openly mourn (Peskin 2000).

Sometimes physically and emotionally marginalised in various settings, male partners are then often expected to primarily grapple with the distressing aftermath; as Graham phrased it, being left “to pick up the mental pieces”. This is not to denigrate the value placed upon care-giving by persons such as Graham, or the numerous comments by women in the research who spoke of tremendous appreciation to their supportive partners or warned of the severe

negative impacts of seemingly apathetic partners. As such, these accounts resonate strongly with Tronto (1993 pp117) that “[c]are is difficult work, but it is the work that sustains life. That care-givers value care is neither false consciousness nor romantic but a proper reflection of value in human life”. However, my concern is that positioning partners and familial/close others predominantly as *providing* support can mask them as candidates for the *reception* of care and support, and dismiss the additional burdens this may place upon them. Some research has looked at the impacts on romantic/marital relationships, finding that marital strain is oft-reported following pregnancy losses (Gold *et al* 2010) as well as other forms of infant deaths (Riches and Dawson 1996), although this may be relatively temporary and in fact give way to strengthened relationships over time (Rosenblatt and Burn 1986). In the context of neonatal death, McHaffie (2001) argues shared trauma brings parents together to create a ‘honeymoon’ period followed by subsequent deterioration of relationships. In relation to this, the care roles within such relationships following pregnancy loss seem a highly relevant consideration.

Whilst women who experience pregnancy losses can “find themselves forced into the role of reluctant “patient”, their partners are often left to adjust to the role of ill-prepared “carer”” (Puddifoot and Johnson 1997 p844; McCreight 2004). I am not suggesting that familial and close others necessarily require the same support as women who physiologically experience pregnancy loss nor am I attempting to delineate the content in terms of the words, actions, procedures, or gestures, of ‘good’ care or support. Rather, I argue that the context of care matters and thinking about care as a *relationship* can expand the scope of roles for all involved to occupy. Many participants suggested that their close relationships were often already characterised by mutual and reciprocal exchanges of support/care in practice, although the content of what these entailed differed. Such an approach emphasises the relational nature of care by underscoring connections *between* actors rather than being unidirectional. For instance, Macpherson’s (2012) research on the relationships between guides and visually impaired persons in rural walking tours emphasises that these entail both the ‘gift’ of responsibility and the ‘gift’ of trust. This recognition complicates and challenges a notion of care as involving fixed roles of an altruistic, active ‘giver’ and a pitied, passive ‘recipient’ (Macpherson 2012). I suggest that emphasising inter-personal, multi-directional support regarding

pregnancy loss might be beneficial in terms of extending recognition to those largely deemed to be ‘support providers’ and allow scope for more varied subject positions than *either* care ‘provider’ *or* care ‘recipient’.²⁶

The Precarious Legitimacy of ‘Familial and Close Others’

Focus so far has been on the ways that ‘external’ others, like medical staff and work colleagues, participate in negating recognition of the potential for ‘familial others’ to be support-recipients (as well as providers); although internalisation is also relevant. The distinction between ‘discreditable’ aspects and ‘discredited’ identities highlights the possibility that stigma can be felt by individuals without any direct social coercion/conveying of this (Goffman 1963). Even if not actually treated as ‘discredited’, the individual can anticipate and/or treat themselves in such a manner, particularly so if the circumstances deemed ‘discreditable’ are not immediately visible (Goffman 1963). In relation to the neonatal death 45 minutes after birth of one baby from her sister’s twins, Siobhan struggled with the intensity of her own emotions of grief which she felt she ought to suppress in order to properly support her sister. Even in the absence of any overt instances whereby social others conveyed this notion, Siobhan felt uncomfortable, perhaps even fraudulent, with the prospect that she might too be deserving of support: “I felt, like, whenever I was in the hospital I shouldn’t cry because I shouldn’t make it any worse or I could set her [my sister] off or I was making it worse when I was supposed to be there supporting her”.

Peskin (2000) highlights comparative bereavement monologues used to assess one’s own felt needs to grieve and mourn against those of others, producing a ranking with subsequent implications for behaviour. In relation to pregnancy loss, ‘familial and close others’ may disqualify themselves from ‘deserving’ support or recognition even without such a message being overtly conveyed by others. Subsequently, Siobhan positioned her own grief as on a secondary ranking and sought to suspend or subsume her own feelings for those (namely her sister) ‘higher’ up the rank (Peskin 2000). Siobhan conveyed feeling a lack of legitimacy in relation to her sister’s pregnancy loss: although

²⁶ Linked to conceptualising care as a relationship are themes of exchange, generosity and the rhetoric of ‘the gift’. In relation to this, it is worth highlighting that some work has drawn upon experiences of motherhood and/or pregnancy (Clarke 2004; Taylor 2004a, 2004b; Hird 2007) as well as pregnancy loss specifically (such as Layne 1999, 2000, 2003a, 2004; Murphy 2009).

she did not have direct physiological experience of the pregnancy and giving birth, Siobhan had been very close to the situation socially, emotionally, tactilely and practically. Owing to the circumstances of the delivery of the twins, Siobhan spent time with her nephew whilst her sister delivered the second baby and had the epidural removed. Whilst appreciative of this opportunity to be with her nephew, Siobhan was aware that her sister had missed out on such a scenario and that, whilst he was alive, her sister “never got to see his body and she never got to see his toes or she never really properly got to see his head because they [medical staff] covered it up [with a hat]”. The tension Siobhan felt between appreciating the intimacy she had shared with her nephew whilst he was alive and the sadness that her sister did not have this was marked:

I was obviously devastated for my sister but I was devastated [for myself] as well because I'd lost my nephew... but I felt, and I still do feel a bit strange because I feel like I can't really talk about my loss because... it isn't MY loss, it's my sister's loss, I didn't lose a baby, but I think I have a bit of a strange, erm... a strange idea of it because I had him, I had more of him, I had more of his life – he spent more of his [postpartum] life with me than he did with his mother and that's one thing I feel a bit guilty about because I got to spend more time with him alive and talk to him, erm, and... sing to him and spend time with him.

Siobhan described feeling simultaneous devastation and joy, as one baby dies and another baby lives from the same pregnancy. The starkness of this situation was recalled in the example of being in a quiet room akin to a chapel of rest: “my sister was on the bed [...] on one side we had a living, healthy baby that was sleeping peacefully and [on the other side] we had a baby that had passed away”. Negotiating these intense and contrasting situations, Siobhan explained that, building upon the aforementioned close engagement during her nephew's short postpartum life, she principally cared for him post-mortem also, whilst her sister focused on the living baby:

we took him home [from hospital] in the coffin, we took the coffin in, but I was the one who put him in the coffin. I know some people find it really strange but I, I was the one who had to like place him in the position that we put him in and we took him

home in the car, in the coffin, but he sat on my knee the whole way home because my sister had the new [alive] baby, but I felt like I couldn't really show, show anything or the relationship that I had because it still wasn't my loss, so, so I had a... weird, weird, emotions {crying}

Siobhan's experience of attempting to manage her emotions demonstrates that additional distress can be produced when the role of support-provision is seen as incompatible (or at least ambivalently positioned) with support-reception. Having one's grief evaluated as lower than others, including by oneself, can have implications like trying not to cry or show her emotions which can deepen anguish (Peskin 2000).

The suppression of her distress, particularly around her sister, constitutes a form of emotional labour (Hochschild 1983) which I suggest Siobhan may have been able to articulate owing to the alternative context of the research interview. Whilst there had been no tangible encounters in which family members or medical staff had implied that her grief ought to be hidden or was diminished in significance compared to that of others, Siobhan had nonetheless clearly internalised this as necessary or ideal. Participating in the research, with a researcher outside of her everyday social context, meant that an opportunity was provided which allowed Siobhan to focus on her experiences without demanding the same degree of emotional suppression that speaking with family or friends might. Such a sentiment about the benefits of speaking to a researcher otherwise detached from the situation was also expressed by a number of other participants; for instance, Fiona explained "that it's a lot easier to be so open with someone I've never met". Resonating with Lupton's (1998; see also Davidson and Milligan 2004) work on metaphors of emotional expression—of flows, pressure and safety valves—Fiona described our email correspondence as validating that she is "allowed" to talk about her experiences:

thank you again for giving me the opportunity, because by talking about it, it helps to deal with it. It stops the experience turning over and over in my head and it gets it out there. To put it plainly, it stops me from bottling it up and ending up one day just cracking.

As Lupton (1998 p90-91) notes, such “language recalls the dam metaphor, where the body is conceptualised as an inner, fluid or gaseous mass of emotions that are held back by the external skin and the will”. In addition to talking, crying was sometimes spoken about by participants as permitting the release of emotions from “the self which sees it as residing within a ‘body-container’ filled with intensities and flows” (Lupton 1998 p98). Crying and tearfulness were most evident (visually, audibly) in face-to-face and telephone interviews but occasionally also in email correspondence. For instance, Isabel wrote of her second miscarriage diagnosed at a 20 week ultrasonography scan: “I will never forget the image on the screen of our little baby lying on his side so peaceful (thinking about it now is making me cry)”. Whilst not wishing to imply that all participants experienced talking and/or crying in the research to be therapeutic or beneficial, nor to overlook the fact that the “logic of self-management” doubtlessly persists (Lupton 1998 p96), it seemed that the research could provide helpful opportunities for some. Hence, I hoped that the research, constituting a space to talk and be listened to, might provide ‘legitimacy’ for Siobhan that she is entitled to support. Through our research encounters, I sought to acknowledge not only her distress at the loss of her nephew but also the additional emotionally-fraught work of hiding the extent of this from her family. Whilst she remained reluctant, despite encouragement from her partner and her mother to consider counselling, I was at least able to tell Siobhan that online support is available for relatives like her who are more readily positioned, or internalise themselves, as support-providers but not support-receivers:

[first interview]:

Siobhan: I don’t feel like I should do that [attend counselling] if my sister isn’t doing it, I don’t know, I feel like I don’t really have the... have the...

Abi: is it like the rights to?

Siobhan: yeah, I don’t have the rights to [...] yeah, I might look into it maybe, erm, but, at the moment, like I feel like I just wouldn’t feel like I have the right to talk about somebody else’s loss, essentially, as if it was my loss.

[second interview]:

Siobhan: I would always assume that the [online support] groups would only be for, really, for parents because I think that if somebody said to me ‘oh what happened?’ or somebody assumed that it was my baby, then I would feel out of place

Abi: Hmm

Siobhan: you know

Abi: yeah, I think that there are some groups that are for, like - erm, there’s, I think, grandparents and siblings and like

Siobhan: I didn’t know there were

Abi: yeah, I think they’re not as easy to find when you search for them but they are there and I can help, if that’s helpful.

Drawing predominantly on the narratives of Graham and Siobhan, this section has reflected on themes of care and support. Their experiences highlight the wider social contexts in which other persons ‘accompany’ women who physically/directly experience pregnancy losses. This includes, for instance, attending ultrasound scans and other medical appointments and being a birth partner during labour and delivery. Recognising care within the context of *relationships* with others can attune us to the fact that support-providers may also benefit from support-reception. Being exclusively cast as a care-provider, by others or oneself, eclipses one’s own support needs. This might include support and recognition from at least some of the sources that pregnancy-losing women also encounter and negotiate, such as other family members, friends, medical staff and, as I now discuss, work colleagues.

Status Disclosure and Work as a ‘Closet’

Many participants found disclosing their reproductive experiences in the ‘workplace’ incredibly difficult and distressing. Although I did not specifically inquire about experiences concerning employment in interviews, many participants raised associated themes, such as working from home, being self-employed, occupations in medical settings, office place politics, maternity provisions (leave and entitlement) and going back to work after pregnancy loss. Not all participants had employment at the time(s) of pregnancy loss(es) nor spoke about work in the interviews and it is also noted that “women ‘do’ pregnancy in different ways, in different workplaces” (Longhurst 2008 p20).

Across an array of employed work spaces and contexts, participants recounted various experiences of disclosure and communication about ‘events’ of, and ‘progress’ within, pregnancies and pregnancy losses. Some of the difficulties around the disclosure of one’s ‘pregnant’ status entail at least an implicit acknowledgement of pregnancy loss and risk, with the commonplace approach being to refrain from ‘pregnant’ disclosure until surpassing the first trimester (>12wks) owing to higher chances of miscarriage during this earlier period. In this section, with regards to the implications of pregnancy loss experiences, I will elaborate on Longhurst’s (2008) use of the ‘closet’ metaphor on the ambivalence of disclosing one’s status as ‘pregnant’ in the workplace. Following this, I will discuss experiences of returning to work and accompanying relations which suggest that workplaces can be precarious environments, rife with the potential for insensitive or unwanted comments, gestures and encounters.

It is worth noting that some participants’ jobs/training, such as in human or animal medicine, had particular implications for their experiences of pregnancy losses. Beth’s occupation as a doctor provided her with background medical knowledge to assess her situation yet, in the context of her own miscarriage, this was also distressing. Her medical training and experiences of everyday work meant that she could visually identify foetal materiality, but she dreaded the possibility that she would do so: “I really thought it would upset me to see a fetal sac etc even though I see them every day”. She explained:

I avoided looking at anything I was passing as I was quite happy in my acceptance of the miscarriage in a medical way, loss of an embryo, probably a non-viable pregnancy anyway. It was just something that happened every day to thousands of women. But somehow if I could have seen the fetal sac, some you can see fetal parts, then I would have lost a baby. I didn't want to grieve over a baby that never was. I didn't want to torment myself.

When Tessa’s pregnancy ended at 15 weeks, her mother-in-law took over her home-based employment of rearing parrots. Whilst it was a relief for Tessa that the practicalities of attending to hatching eggs and baby birds would be covered whilst she recovered, knowledge from her veterinary work history remained troubling. In particular, Tessa described abject horror in the wait for the D&C procedure: “maybe because I had worked at a vet and seen a lot of dead animals,

[I] don't know, but I couldn't take the idea that I was already carrying the baby for two weeks and all the time it was dead". Trulsson and Rådestad (2004) also found that this aspect of a diagnosed intrauterine death can be psychologically traumatising and prompt an intense desire to have the deceased body removed immediately. Additionally, Tessa was deeply distressed at possible resonance between her veterinary experience of dissecting deceased animals and what might occur in a post-mortem investigation:

[t]hat really creeped me out [...] you know what they do [in histology], putting everything in formalin and cutting it in thin slices. I was crying the whole day, because I thought that is what they would do to our baby. But I couldn't tell my husband, I didn't want him to know this.

Thus, there were some participants for whom their work lives provided some additional layers to their experiences of pregnancy loss, informing fears about physical encounters with and possible treatment of foetal materiality.

Work spaces can be understood as simultaneously professional, semi-public environments with 'acquaintances' *and* familiar, semi-private and shared settings with friendships of varying degrees. Subsequently, they can be difficult places to socially negotiate. Longhurst (2008) uses 'the closet' concept, based on queer and sexualities research, to think about the disclosure of one's 'pregnant' status in the workplace. Drawing on Brown's (2000) articulation of 'closet space' as entailing simultaneous concealment (absence) and materiality (presence), Longhurst (2008) demonstrates this as pertinent to a range of issues around disclosure. Workplaces are just one 'closet' of many in which careful negotiations are made as to one's pregnant status (Longhurst 2008). Initially interested in practices of showing or hiding pregnancy bumps in public spaces, the research behind Longhurst's (2008) discussion on the workplace 'closet' highlights a range of issues which also featured in the narratives of my participants. This includes: pressures from employers; physical exhaustion; reputation and career trajectories; and not wanting to be seen as 'incompetent', 'troublesome', 'overly emotional' or otherwise 'disruptive' to/in the workplace (Longhurst 1997b, 2008; Thomson 2011). Longhurst (2008) recognises that the complex reasons as to why such announcements at work of 'being pregnant' can feel risky, shameful and anxiety-inducing actually include concerns about

pregnancy loss: a fear of miscarriage, particularly if this occurred in a previous pregnancy, and recognition of sensitivity given that others in workplaces may have experienced pregnancy losses themselves. Thus, pregnancy losses feature, albeit in somewhat largely unspoken ways, in the negotiation of disclosing one's status as pregnant and I argue that the workplace can also be a 'closet' when it comes to disclosing the occurrence of pregnancy losses.

Expanding Longhurst's (2008) work on the difficult negotiation of disclosing one's status as 'pregnant', pregnancy loss can then necessitate an additional and distressing 'untelling'. Both Beth and Jane explained how their jobs in hospitals meant that their colleagues became aware of their pregnancies quite early which, following miscarriages, meant having to also disclose these. Beth explained how particular non-verbal gestures/practices and verbal clarifications in her work context functioned to disclose her pregnant status:

although I had not told my friends or family, I was forced to tell everyone at work [that I was pregnant] so that I could avoid transferring people to the MRI scanner, avoid the patient with Swine flu and chickenpox etc etc. [...] [Additionally, gestational diabetes meant that] I was forced to test my blood sugar after meals - well in the hospital it is not a very private place and when lunch is had in a meeting you have to test your blood sugars in that meeting and when you start doing that when you have never done that before people start asking questions[.]

Since Beth had been required to tell her colleagues about her pregnancy, after her pregnancy loss she "then [had to] untell them..." Such a situation of one's colleagues knowing about a pregnancy means that the potential range of persons to then inform of pregnancy loss can be extensive. If snowballed, the range and number of these individuals may exceed that which the person had told or thought knew about the pregnancy. As Jane commented, "the gossip grapevine on our unit moves very fast! I think I only told one or two people, but it only took a week or two before everyone else knew [that I was pregnant]".

Subsequently, the experience of 'untelling' colleagues can be suspended across a significant period of time after the event of pregnancy loss and entail unwanted encounters with near-strangers. During participation in the research,

nearly three months after her miscarriage, Jane said: “I have found it hard when colleagues who knew I was pregnant, had not heard what had happened, like a few weeks ago when I was asked how many weeks pregnant I was now, which caused a lot of embarrassment”. In contrast, for some women, their work colleagues were the first people to know that pregnancy loss had occurred or was occurring due to physical proximity, social familiarity and time spent together in the workplace. Lisa described first discovering uterine blood loss, indicating her second miscarriage, whilst at work and that the colleagues in her office had been aware that she was nearly 10 weeks pregnant. In this instance, in the context of relatively few staff in her office, Lisa’s colleagues were ‘un-told’ about the pregnancy through the physiological symptoms of miscarriage that she was experiencing then-and-there, and with one colleague also accompanying her in seeking medical assistance. She explained:

I had gone into work but didn't feel right and just put it down to slight morning sickness. I went to the loo and saw some blood spotting and panicked. I went back into the office to ring an ambulance but one of my colleagues offered to drive me to the hospital instead. When I got to the hospital I was examined and told that everything looked fine but I would have to go and drink some water before I could have a scan. My colleague waited with me until my partner arrived.

Participants suggested that different working environments and specific inter-personal contexts had a bearing on whether they felt able (or not) to disclose fertility difficulties, pregnancies and/or pregnancy losses. Rosie described her work office, consisting mostly of women and many of whom were of ‘child-bearing age’, as one in which reproductive and mothering ‘chat’ featured significantly. However, as Longhurst (2008 p36) highlights, “[b]eing in a female-dominated workplace doesn’t necessarily guarantee that disclosing a pregnancy will be ‘easy’ and that just the right amount of support/advice (not too much, not too little) will be forthcoming”. Notable ambivalence towards such a scenario was recounted by Rosie and also extends to difficulties of disclosing pregnancy losses such as miscarriages:

there was one other girl [at work] who was very open [...] that she had had one bout of IVF because she had polycystic ovaries and it

had worked and then she'd had another and she was pregnant with twins, so everybody knew about that but you still had to be very... secretive I think. Another girl had a miscarriage and nobody talked to her about it, openly with her, everybody *whispered* about it and that gave me that 'oh okay, I need to be secretive about this' sort of atmosphere [...] [My colleagues will] sit there and talk about their little boys potty training and they're very open about those aspects of their lives whereas I talk about it [fertility, trying to conceive, pregnancy, miscarriage] to a trusted few and that's it.

Just as Martin (1987) suggests that menstruation does not 'belong' in the realm of work according to cultural categories, it seems that a similar message can be spelled out that neither do miscarriages or other reproductive difficulties as Hazen (2006) also found. Rosie had spoken with her employer about the company policy on flexibility for time-off from work to attend IVF treatment appointments; however, in doing so, she sought to negotiate how much information about her IVF treatment she divulged with her employer and colleagues as well as family and friends. She did not want to have to explain the details of, and give updates on, which steps of IVF were happening (such as follicle-stimulation injections, embryo implantation and check-ups):

I had to tell my boss 'this [IVF] is what my appointments are for, please don't tell me that day is not good for you because I really can't change it' sort of thing and told the girls at work that 'look, I am going through IVF' – the people that you see every day we said to 'we're going through IVF, please don't try and tickle me; if I'm covered in bruises - it's not because I've got a drug habit all of a sudden' {laughs} sort of thing but we only really told people on a need to know basis because they were going to see me with bruises and disappearing for appointments. I didn't even tell my best friend, just said we were waiting for IVF and on the waiting list. Erm, then we lost the first one, we just sent an email to our parents and best friends saying we'd been through one cycle and unfortunately this is what's happened, we're going to wait a few months and then try again sort of thing.

Whilst not specifying which steps/processes she was undergoing in IVF *per se*, the pattern of time-off for appointments that Rosie's work colleagues observed did play a part in establishing their knowledge of what may be occurring. Rosie explained that, prior to seeking fertility treatment, she experienced a miscarriage which no one at work knew about since this had been a naturally-conceived pregnancy and thus for which "they hadn't seen me going for any appointments". In contrast, the regimen of appointments 'revealed' the (prospect of) pregnancy, necessitating the telling to some familial and close others, which then entailed an 'untelling' with subsequent loss:

everyone began to notice when we were having appointments this time round, it's just they went on and on because we were having weekly scans – we did tell people {sigh} because it gets so hard hiding it and it's easier to say 'this is what's happening, we're not sure what the outcomes going to be and we don't really want to discuss it but just to let you know', but then when it was all over [with a miscarriage] and [my husband] was away, obviously I needed to tell people pretty quick because obviously I needed the support.

Returning to Work and Colleague Relations

Many participants spoke about the experience of going back to work after their pregnancy losses as anxiety-inducing, with uncertainty as to how colleagues would respond. The potential for insensitive and intrusive comments or questions was a concern for some whilst, for others, the prospect that their experiences might be ignored altogether was also upsetting. Several participants explained that the news of their pregnancy losses had been broken to their work colleagues in their absence through either their boss or a key colleague-friend. For instance, on diagnosis of a late miscarriage, Isabel initially requested that her employer not tell others in her office and then, after the delivery, gave permission for this news to be shared. She received some text messages of condolences from colleagues, although Isabel felt strongly that she did not want to talk to colleagues about it. Concerned about her return to work one month after her late miscarriage, Isabel explained that she had her hair cut and dyed as a way to deflect some of the attention:

it was very awkward when I went back to work, so I'd decided to [...] change my hair so I got it all cut short and went brunette, just sort of like as a talking point, you know, just so that when I went back to work everyone went 'oh wow, I like your hair' and [...] so they didn't have to talk about what had happened.

Isabel explained how this aesthetic change "was a HUGE thing for me to do {laughs} I've always had long blonde hair so for me to go short brunette was a big change" which, in addition to being a decision deliberately intended to manage her return to work, it was also "symbolic, it was representing my erm... period of mourning I suppose. So, erm, I was brunette for a good few months, for about six months".

Though speaking in another context, of women who have experienced violence during their adolescence, Springer (1997) highlights that alterations to one's own physical body can be understood as acts which deliberately demonstrate the exercise of agency. Particular forms of 'pathological' body modifications, such as self-cutting and eating disorders, have been closely aligned with trauma theories in the literature (Favazza 1996; Strong 1998) However, other forms of less harmful bodily modification may also to be linked to efforts to assert ones' agency, particularly following circumstances that have been deeply upsetting and beyond ones control. Therefore, Isabel's act of dyeing her hair can be understood as an exertion of her agency in response to her powerlessness to prevent the traumatic pregnancy loss and the anticipated difficulties of her return to work. The topic of body modification will be discussed in Chapter 7 in relation to skin-based marks like memorial tattoos and Chapter 8 will attend to memorialisation and mourning in more depth. As a result of her hair dyeing change, Isabel implied that her return to work had been largely uneventful in the manner that she had hoped and thus 'successful' in terms of exercising her agency as to others' responses to her:

[a member of management] came over to me and said 'oh it's good to have you back, I'm pleased to see you' and I thought awr that's really nice for her to say that – whereas everyone else, they just sort of... they didn't really acknowledge it apart from erm... which was what I wanted, that's what I asked for, I said to my boss that I

didn't want a fuss or anything and... so I'm pleased they didn't make a fuss because it would of upset me.

As with Graham's experience mentioned earlier, disclosing pregnancy loss at work can entail vulnerability to insensitive or awkward remarks, actions and gestures; however, there can also be scope for unanticipated solidarity. Sometimes, as was the case for Jane and Holly, participants had not been able to 'untell' all their colleagues and work-related acquaintances prior to being asked about the progress of their pregnancies. Holly commented:

within my first week back at work [after my miscarriage], a couple of women that I've worked with for years and years and years, that I've known for a long time, had known I was pregnant and I went to a meeting and they were there and they hadn't known I'd lost the baby and they were 'how're you doing, how's it going?' and so on and I said 'I lost the baby'.

Whilst having to 'untell' was distressing in recalling difficult and 'raw' experiences, the responses from Holly's colleagues on this occasion were appreciated as supportive. As it turned out, the women then disclosed that they had all experienced pregnancy losses and/or fertility difficulties but had not previously shared this with each other.

However, some participants recognised that comments or encouragements, such as to talk, from work colleagues, which may be seen as 'supportive' for one person who has experienced pregnancy loss are actually intrusive and uncomfortable for another. Isabel discussed the difficulty of gauging suitable responses or approaches preferred by other people who experience pregnancy losses:

[pregnancy loss] is a really awkward subject and even now say, god forbid, somebody at work did have a miscarriage, even though I've been through it, I still wouldn't know how to deal with them because it is, you know, it is... it's tricky, isn't it {laughs} it's really awkward to know what to say to people, like my mum saying to me 'ohh don't worry, you can have another'... you just don't want to hear that {laughs} it's a terrible thing to say {laughs}

Isabel described an occasion in which a colleague took her aside to tell her that her grandchild had been born “because she didn’t want me to find out through the grapevine, but erm... yeah but it didn’t help {laughs} she didn’t do the right thing {laughs} because I got just so upset about it”. Whilst this forewarning may have been appreciated by some, it was not the case for Isabel; equally, what helped Isabel in this situation may not have been appreciated by others:

after she [the colleague] talked to me and told me, I was trying to sort of like hold myself together so I went to go and talk to somebody else about work and I was talking to her and I was just like crying as I was talking to her and my tears were dripping all over the paper {laughs} and she said ‘[Isabel], just go for a walk, just go and pull yourself together’ sort of thing so I was like ohh okay, so that’s what I did.

Disclosing one’s experience of pregnancy loss could potentially partake in the creation of relatively fleeting connections or new relationships with work colleagues, entailing scope for empathy and sympathy. Notably, the event of one person sharing the fact of their pregnancy loss can serve as a catalyst for bringing together multiple generations of individuals with similar/related experiences whom one might not have previously known much or at all. In the earlier example of Holly’s untelling, it seems that the recentness of her miscarriage triggered some of her colleagues own memories of pregnancy losses from decades ago which they then felt compelled to share:

I don’t know them that well and we’re not immediate colleagues, it just happened to be that they all knew I was pregnant [...] and had just asked basically how I was doing and they just, I was just amazed – all three of them [had had pregnancy losses or fertility difficulties] just kind of, yeah, and they obviously had never mentioned it to each other but then why would you, if you’re not going through it then and there.

In such encounters in which others share their experiences of pregnancy losses, the difficulties of reproduction are exposed and the frequent occurrence of miscarriage is somewhat normalised rather than remaining hidden. For Holly, this also offered hope of a future healthy pregnancy: “it’s nice to know that

people have been through it and also they all had children since which makes me feel a lot better”. Pregnant for the second time during our interviews, Holly was acutely aware that others who knew/saw that she was pregnant might assume, as she had previously of others, that her conceiving and carrying the pregnancy had been straightforward. Occasions in which one discloses experiences of pregnancy loss, sometimes with reciprocal disclosures by others, can thus be understood as important on a wider scale. That is, talking about pregnancy losses and reproductive difficulties with others can de-mystify the dominant discourses Layne (2003a, 2003b) identifies which equate pregnancy with being joyful and natural. As Holly explained:

people assume that if you're pregnant or if you've just had a baby that everything's been easy for you and fine but most people I've heard from have had a niggle or worry or whatever it might be or it's taken them years to conceive or something but people just don't talk about it and I think if you did, if people did {laughs}, we'd just help each other out a bit more [...] [In relation to a conversation with a friend] I know it's horrible to think that me telling her I lost a baby makes her feel better about me being pregnant now, but *it does* and you can't kind of deny that fact. If it's dead easy for everyone around you, 'cos that's how I felt, like everyone around you is just quite happily getting pregnant, having an easy pregnancy and then having a lovely baby at the end of it – [...] now I kind of think you can't assume that.

Supporting the notion that 'untelling' can help form bonds between women who have experienced pregnancy losses, these relationships may also be drawn on in coping with subsequent triggers in the work environment. Whilst Rosie's employer was accommodating to her needs regarding IVF treatment, such as giving time off to attend appointments, occasions cropped up at work which were sometimes triggering of her experiences of miscarriage and fears about infertility. Rosie explained how, when work colleagues announce their pregnancies, "I always have to go and take myself off to the toilet for five minutes to feel sorry for myself and have a little sniff and just sort of compose myself as it were". On one occasion, this scenario became one of mutual support between Rosie and an otherwise scarcely-known colleague as they shared not

only their sadness at their experiences of ‘reproduction gone awry’ (Jenkins and Inhorn 2003) but also practical information and reassurance:

I could hear someone sobbing away next door in the cubicle, so we were both sobbing away together. I said ‘are you okay?’ and she was like ‘not really, are you okay?’ and I was like ‘not really’ and I knew she wasn’t going to say anything first so I went ‘oh, well, I’m sad because [another colleague] is pregnant and I’m not’ and she went ‘well, I’m sad because [colleague] is pregnant and I’m not’ and so we came out and gave each other a hug and so forth [...] she was like ‘I’m on this [fertility] drug called Clomid’ and I was like ‘yep, been there, done that!’ and she was like ‘did you notice any differences?’ and I was like ‘yes, I was a BITCH’ and she was like ‘yeah! Me too!’ and she’d never talked to anyone about it, she hadn’t even read the books that I [had] read, so it all sort of came tumbling out and I was able to say ‘you’re actually absolutely fine and completely normal to be acting that way’ – so that’s been... not nice, but sort of good that I’ve been able to help her.

Many toilets beyond the home, including in workplaces and public toilets in shopping centres, are committed to sexual segregation and gendered certainty with separate toilets for men and women (Schapper 2012). Whilst toilets can be a site of fear around ‘dirt’/contaminants but also the threat of physical and sexual violence (Schapper 2012), disgust and repulsion (Longhurst 2001) – the above example of Rosie also highlights the potential ways in which these spaces can be conducive to emotional support and reciprocated care. ‘Private’ locations may be used in subversive and solidarity-inducing ways (Martin 1987) and, given the wider context in which pregnancy losses are dismissed, I argue that this example can be read as such. Online pregnancy loss support groups are another location where people (usually women) who otherwise would not know one another offline can potentially share their experiences openly and unapologetically. The emotional ‘risks’ of sharing one’s thoughts with semi-strangers may, with relative anonymity of oneself and others, actually be beneficial and the relations between online support group users facilitated by the groups can be very rewarding, providing sympathy and/or empathy and practical information (as will be discussed in Chapter 6).

Whilst there is potential for new, valued relations to be forged with others in the workplace and sub-spaces within these, some participants were conscious of the risks of sharing their experiences across multiple domains of their lives. With hindsight, some encounters of disclosure were seen as more prolific, dispersed or uncontrollable than later preferable and could give rise to retrospective regret or uncertainty about how this may have been received. Gemma suggested that talking about her experience had been a kind of compulsion, she explained:

[j]ust after it [late termination owing to foetal spina bifida] happened to us, I had to tell everybody, virtual strangers and baby groups (upon the conception of my second pregnancy). [T]hat went on for a good two years, it was like some kind of confession. I don't know what people thought about this, but I had to get it out all of the time.

Given the ambivalence around the context of terminations following positive foetal anomaly diagnosis, a confessional-compulsion can be understood as pertaining to complex, multifaceted emotions. This contrasts with the findings of Rillstone and Hutchinson (2001) that women who have had terminations after diagnosed anomalies tend to limit disclosure of these past experiences in subsequent pregnancies, owing to the re-emerged rawness and fear that others would judge. 'Shame', a word used by Gemma in a subsequent interview, is explored by Probyn (2005) as a powerful, bodily intensity which can have varied subsequent effects (see Duncan 1994 on dieting). Subsequently, silence and secrecy are not the only possible responses. Scarry (1985) argues that 'confessions' are demonstrations of one's world destroyed by extreme physical pain, to which I add that intense emotional pain is also capable. Anne also described a situation in which a kind of 'blurting out' experience occurred in the relatively mundane setting of a supermarket with an unknown other (a cashier):

there's one or two people who I made the mistake early on of telling, just random people {laughs} which I don't do any more, you know. Unless I was pushed to, I would never purposefully just tell random people but like – when I was in the supermarket [shortly] afterwards and [... a female cashier assistant] was kind of badgering me going well erm 'oh is it your day off today?' 'no, I'm

not at work at the moment’ ‘arr why are you not at work at the moment?’ {sigh} ‘I’m on leave’ ‘oh right are you off sick or something?’ ‘no, I’m on maternity leave’ ‘arr that’s nice, when do you...’ ‘right, my baby died’ {laughs} and that just shut her up which felt really awful.

Though this specific supermarket instance was fleeting, the emotional legacy held importance potentially because it resonated with the uncomfortable/silent responses from known others (including close friends). As Bowlby (2011) demonstrates, friendships are an important form of care for most people, involving co-presence in spaces such as the home. However, finding that “people don’t know how to respond to it [stillbirth], it’s a very frightening thing, people don’t know what to say to you”, Anne had not always received the kinds of care and support expected/hoped for. She explained:

I had a friend who I was very close [to] – who I’m now not close to because... she just has had no idea what to say, she’s a bit frightened of talking about it and about him [my son] and what happened, so she’s been SPECTACULARLY unsupportive.

Anne recognised a cultural discomfort with deaths unsettling the linear trajectory of ‘birth-life-death’ (and potentially rebirth/reincarnation – Minogue and Palmer 2006), that “people don’t want to discuss babies or children as deaths at all” because it “feels very unnatural to have your children die”. However, the consequences of this societal discomfort for Anne was to render talking about her experiences, which also included miscarriage and fertility problems as well as stillbirth, even more difficult and vulnerable to insensitive or unsupportive responses and non-responses.

Concluding Remarks

McLean and Flynn (2012 p2) comment that miscarriage—to which I would add other kinds of pregnancy loss including stillbirth, terminations and neonatal death as well as fertility treatments—are “not merely” medical conditions or events, but also “emotional experience[s] with consequences stretching beyond the hospital stay”. Thus, pregnancy losses ‘stretch’ beyond the moment and location of occurrence, and are wider social experiences concerning different persons, places and times. The first section of this chapter,

attending to partners and familial close others, foregrounded the themes of marginalisation and de-legitimisation. As shown, male partners like Graham can be side-lined in various ways within medical settings, workplaces and more broadly by friends within social circles. Whilst there have been some shifts which recognise that pregnancy is more than solely a 'woman's issue' and attempts to incorporate male partners (Draper 2002a, 2002b, 2003), recognition available to men in relation to pregnancy losses often remains limited in practice. As O'Leary and Thorwick (2006 p82) argue, "now men's roles are seen as helpful but mostly in terms of how they can support their partner". Difficulties in coming to terms with one's own experiences, including emotional grief and the 'right' to express this, also emerged in relation to Siobhan who had been intimately involved in the short life of her baby nephew.

In the second section of this chapter, I considered participant narratives which suggested that disclosing pregnancy loss at work can be distressing and difficult to navigate. This can concern not only the recall of often physically and emotionally painful experiences but also vulnerability regarding potentially insensitive comments and actions by others. The 'closet' concept, utilised by Longhurst (2008) in relation to announcing pregnancy, captures the profound ambivalence of disclosing pregnancy losses with simultaneous anxiety and the prospect of relief for 'coming out'. Negotiating knowledge about one's reproductive context in the workplace was a source of concern for many participants and 'untelling' could be a protracted endeavour, as for Jane and Holly after their miscarriages. It is, of course, not only 'familial and close others' or work colleagues who shape experiences of pregnancy loss; additional persons and groups feature elsewhere in the thesis, including medical staff (most evidently in Chapters 3 and 5) and online support group users (Chapter 6). All of whom can be involved in the 'social policing of grief' in terms of the ways that emotions and responses to losses are societally shaped and regulated (Walter 1999; Peskin 2000; Small and Hockey 2001).

I have argued that pregnancy loss experiences are social as well as medical, and indeed biological processes can have intense social significances. For instance, uterine bleeding featured in nearly all participants' accounts as a particularly disruptive and abject bodily fluid, requiring concealment from the view of others as well as potentially from oneself, such as during menstruation

(Martin 1987; Vostal 2005; Bobel 2010). The negative social connotations regarding uterine blood constitutes an example of the ways additional persons and communities are involved in processes and meanings regarding pregnancy losses, highlighting these as inter-personal and relational experiences. Indeed, pregnancy can itself be considered to challenge neoliberal notions of individual body-selves since, “[f]or any woman, [...] pregnancy will raise questions about her sense of identity and embodiment. Is the foetus part of one’s body/self, or is it separate? Where do I, the woman, begin, and it, the foetus, end?” (Lupton 1999 p78; see also Draper 2003). Franklin (1991 p203, italics in original) argues that pregnancy complicates and refutes the ease of an individualising approach:

[t]he very term ‘individual’, meaning *one who cannot be divided*, can only represent the male, as it is precisely the process of one individual becoming two [or more] which occurs through a woman’s pregnancy. Pregnancy is precisely about one body becoming two, two bodies becoming one, the exact antithesis of in-dividuality.²⁷

Pregnancy loss can subsequently mean encountering ambiguous fluids and materiality, including that of uterine blood flows, clots and kinds of (embryo, foetal, baby and placental) bodies; a topic I will now discuss in Chapter 5.

²⁷ Indeed, the argument has been made that all bodies—not only pregnant bodies—are always already multiple and complex, with sensations and emotions connecting both within and between bodies (Dixon and Straughan 2010; Abrahamsson and Simpson 2011; Colls 2012; Lea 2012). As Paterson *et al* (2012 p14) state “the body is not a bounded, unitary object, but emergent through relations including sensory ones”.

Chapter 5: Bodily Fluids and Flows

Introduction

Bodily fluids and flows are unavoidably present in relation to life and death (Hallam *et al* 1999) and, in the case of pregnancy losses, simultaneously so. A key response towards bodily fluids and flows has been of disgust, aversion and abjection: “ultimately the basis for all disgust is *us* – that we live and die and that the process is a messy one emitting substances and odors that make us doubt ourselves and fear our neighbors” (Miller 1997 pxiv, spelling and italics in original). This is not purely based on bacteriology knowledge or evolutionary responses to threats of disease (Miller 1997; Curtis 2007); rather, complex social and cultural influences participate in the articulation of responses such as disgust, the “most embodied and visceral of emotions” (Miller 1997 pxii). Prevalent culturally determined hierarchies of bodily fluid secretions identify some, like uterine blood, as particularly polluting (Kristeva 1982; Bobel 2010). Conceptualisations of some bodily fluids as ‘dirty’/‘dirtier’ than others are “an issue of ranked purity, not of scientifically valid rules of hygiene” (Miller 1997 p176). Thus, responses to bodily fluids like uterine blood and breast milk are not simply about the physical characteristics of the liquids or germ/bacteria ‘risks’: “bodily fluids create anxiety because of the threat they pose to self-integrity and autonomy. Bodily fluids threaten to engulf, to defile; they are difficult to be rid of, they seep and infiltrate” (Lupton 1996 p114). As I will discuss in this chapter, there are often complex and additionally intense emotional responses to bodily fluids and flows when a pregnancy ends abruptly and/or distressingly.

Douglas’ (1966) seminal insights on ‘dirt’ as matter out-of-place have been utilised by Murphy and Philpin (2010) to consider early miscarriage. With relevance also to other forms of pregnancy loss, Murphy and Philpin (2010) argue that it is widely deemed unacceptable to speak openly about blood, clots and ‘products of conception’ (embryonic/foetal entities). Murphy and Philpin (2010 p540) comment that nursing practice tends to privilege the psychological components, with implications for care, over “the [woman’s] physical body”, echoing with my own assessment regarding much of the existing pregnancy loss literature. The result being that “this part of the women’s experience remains private to her and further serves to distance her from the wider culture” (Murphy and Philpin 2010 p540). Hence, I have sought in my research to attend

to both the ‘physical’ bodily and emotional dimensions of pregnancy loss experiences. I argue that encounters with particular fluids and matter in pregnancy losses links to, for example, contemporary funerary practices suggesting that it is beneficial for the bereaved to see the body of the deceased to facilitate ‘grieving processes’ (Worden 1993). Historically, as Davidson (2007) notes, stillborn babies were rapidly taken out of sight whereas the contemporary approach tends to be encouraging the seeing and handling of the deceased baby by women and potentially their partners/wider families to ‘produce’ memories and memorial objects. However, some research has supported restrictions on viewing and touching the bodies of stillborn babies (Hughes *et al* 2002), participating in ongoing considerations about this issue (Godel 2007; Ludlow 2008; Hunt *et al* 2009; Rådestad *et al* 2009; Hochberg 2011).

In relation specifically to comments by Cohen *et al* (1978), Murphy (2009) comments that a focus on confirming ‘reality’ through seeing foetal/baby bodies overlooks embodied aspects such as the fact that the production of breast milk continues after stillbirth. This chapter will consider this and some additional bodily fluids and flows as well as encounters with the materiality of foetal bodies (see also Chapter 7 on other forms of ‘bodily evidence’ such as stretch-marks). Discussion here will be on uterine bleeding and passing, and—to lesser extents—lactation, tears (crying) and vomit (morning sickness) to consider some of the ambiguities regarding participants’ encounters with these bodily fluids, flows and matter. As I will argue, uterine bleeding in miscarriage can often be experienced as somewhat betwixt-and-between menstrual blood and mortuary visitation. Building on my earlier discussion of ultrasonography (Chapter 3), this has particular implications for thinking about the spatialities of grief, bereavement, death and dying. This supports my efforts to move beyond—for instance—hospices, care homes and resuscitation wards as spaces of death and/or forthcoming death to consider how pregnancy losses entail a range of other kinds of locations at which encounters with death and dying often occur, including that of A&E and in the toilet/bathroom of one’s home.

Encountering Uterine Bleeding

Bodily fluids and flows are crucial to cultural understandings of pregnancy, with amenorrhea (the cessation/absence of menstrual bleeding) and nausea (morning sickness) widely considered indicative, whereas the end/

ending of pregnancy is often accompanied by blood (such as in miscarriage bleeding). Since bodily fluids and flows are generally deemed taboo and, especially in the context of pregnancy losses, can be highly sensitive and emotive topics, careful negotiation was required in my research practice (see Methodology chapter). However, I considered such an endeavour important since there are a range of pertinent, meaningful experiences involving bodily fluids and flows which may otherwise be overlooked or silenced. This is often the case in nursing practice (Murphy and Philpin 2010) and in one's social encounters with family and friends as well as, I suggest, within the academic literature. Speaking as a historian tracing how ideas have emerged and developed about pregnancy and the human foetus, Duden (1993 p63, 1999) notes that uterine bleeding during suspected/prior to quickening pregnancies in the eighteenth-century were largely considered "neither an argument against pregnancy nor a reason to be particularly upset". In contrast, for most of my research participants, bleeding during suspected or confirmed pregnancies was often experienced as a distressing sign indicating jeopardy if not loss.²⁸

In relation to miscarriage, light bleeding which then became heavier and/or prolonged was often considered "an important marker" which "signalled" occurring or forthcoming pregnancy loss (Murphy and Philpin 2010 p537). The experience of uterine bleeding for participants, indicating or as part of pregnancy loss, varied in relation to: the length of the pregnancy/gestational age or size/weight and thus medical classification of loss, with implications for treatment; medical treatment/processes (natural/expectant, medical or surgical management of early missed miscarriages); the location(s) of loss(es) such as the EPU, at home or at work; and aspects such as the temporality, duration, heaviness and accompanying pain of pregnancy 'losing' or post-pregnancy loss (recovering from a surgical procedure). I will focus on earlier losses given the

²⁸ Light bleeding or 'spotting' can be indicative of implantation (embedding of the blastocyst into the endometrium) or, as in Tania's experience, non-harmful ovarian cysts. However, the significance of some bleeding is often very difficult to determine. For instance, Tania had experienced some light bleeding in her first pregnancy (ending in full term live birth) and so she was not concerned when some spotting occurred in her second pregnancy. However, when the bleeding became heavier and with persuasion from her mother, she attended hospital where "within minutes of me sitting on the bed I felt something come away. Without going into extremely graphic details, I lost the baby" and a D&C was performed that evening.

primacy of blood and bleeding in these accounts compared to a recognisable 'baby' and 'birthing' processes in later losses. This will involve considering the experiences of Jane, Holly and Carla, respectively concerning themes of decision-making about management of confirmed early miscarriage, uncertain parameters and preparation regarding 'normal' miscarriage bleeding, and the emotional experiences of blood loss regarding fear and embarrassment.

Participants whose pregnancies were diagnosed as missed or partial miscarriages often faced decisions about their management. For instance, having experienced no prior bleeding, Jane found out at the 12 week ultrasound scan that her pregnancy was anembryonic and had not progressed past the three to four week growth stage. Jane spoke with a registrar who informed her about available treatment options, weighing up that of natural/expectant (indefinitely waiting until bleeding begins), medical (chemical inducement) and surgical (manual procedure to remove uterine contents): all of which tend to involve uterine bleeding to varying degrees. To supplement the information provided at hospital, Jane also sought out information about the management options online when she returned home. She described the reasons behind her decision of surgical management: "I felt with the ERPC that the 'messy bit' would all be dealt with whilst I was under anaesthetic, whereas I think I would have been worried if I had been at home bleeding [with natural/expectant miscarriage management], not really knowing what was happening". Another aspect reinforcing Jane's decision to opt for surgical management was her knowledge of a friend's sister who had "had a pretty awful experience with a medical management which was very off[-]putting!":

[m]y friend described her [sister's] experience as being a very long, drawn out miscarriage, with a lot of pain and bleeding. Despite my friend, her sister and her mother all being nurses, it sounded like they were all very scared about the amount of blood she lost, and whether she should have actually gone back to hospital. Her 2 young children also were there at the time, and I think were quite frightened by what was going on [Jane's own child was 18 months old at the time of her miscarriage].

Related to the previous discussion on the social context of pregnancy loss in Chapter 4, this can be seen as an example in which talking with others produces

a network of people whose experiences then intersect in some way with one's own; in this case, the account of her friend's sister's pregnancy loss reiterated Jane's miscarriage management decision. This is often, as for Jane, alongside the use of Internet sources and support groups (to be elaborated in Chapter 6).

Uncertainty regarding the distinction between 'normal' and 'worrying' experiences within miscarriage, including both bleeding and pain, emerged in a number of participants' narratives. Smith *et al* (2006) also found this lack of information to be a major problem encountered by the women who took part in their research. For example, Holly subsequently turned to the Internet to gain further information about the physiological experiences of miscarriage at just under 10 weeks but felt there was a dearth of comprehensive accounts:

I still don't know whether that's [very heavy bleeding and intense pain] normal – I've not read ANYONE else's detailed description of what happened to them.

Additionally, with her husband being a GP, Holly drew upon her personal network of family and friends to access pain management and sought to 'prepare' herself. However, the limitations of medical professionals' understandings of such experience was highlighted since her husband "had never seen anybody go through it and he said, you know, people come in having had a miscarriage and they'll say it was very painful and he had NO concept of what that meant". As mentioned in Chapter 3, her mother had personal experience of miscarriages, although Holly had not really known about these prior to the onset of her own. Concerned not to frighten Holly, her mother was reluctant to discuss the physicality of her own miscarriages and only divulged when realising this silent omission was itself having the undesired effect of inducing panic. Though her mother's miscarriages were felt to have limited practical relevance for Holly's, having occurred several decades ago in a different treatment context, the lack of willingness to talk about the physical experience was marked. Part of her mother's reluctance may have also related to her step-father's optimistic approach: "he kept saying, you know, 'this happens

all the time, it could be absolutely fine', but I really knew it wasn't fine and it was getting heavier and heavier and I was getting more pain".²⁹

When she initially started bleeding, Holly's husband encouraged her to go to A&E but her experience there was upsetting, not only because of her fears about losing the pregnancy but also owing to the environment and treatment by medical staff:

you don't have to triage on a huge open counter top with everyone and anyone standing there and what if I'd gone in with lots of blood and lots of pain and standing there and being asked 'are you passing clots? How many? Are you doing this and are you doing that?' and that's while you're standing next to a guy [porter] with a ladder waiting to be told where to put a light bulb in and you think, you know, that's not good, that's not good. It makes you feel ridiculous, like a hypochondriac as well and all 'people bleed in pregnancy, you'll be fine' when actually I think people know their own bodies and know when – I certainly felt like I wasn't, it wasn't going to be okay.

Holly foregrounded her participation in the research in terms of wanting to contribute to readdressing a lack of knowledge and advice about the physical experiences of miscarriage (blood loss and pain) from both 'medical profession' and 'lay' sources. In addition to participating in my research, she had also undertaken other activities to contribute her personal experience about miscarrying, namely writing a blog and featuring in a women's magazine article. She positioned herself as "lucky" in contrast to the "exceptionally isolating" experiences of women who lack practical and/or emotional support during pregnancy loss. Holly described herself as having both emotionally supportive family and friends, and also benefitting from several family members deemed to have 'expert' status by virtue of occupation (with her husband and step-father both GPs, their colleague-friends, and her mother having been a midwife). However, Holly questioned the reliability of these 'expert' knowledges; for

²⁹ It may have been that Holly's step-father was attempting to enact a kind of 'swan effect', attempting to appear serene to disguise concern, which is a notion Scamell (2011) uses regarding the difficulties faced by midwives in balancing intense vigilance and activity with calmness and positivity in labour.

instance, when she posed questions about the ‘mechanics’ of loss such as how much blood she would lose, for how long she would bleed and how much pain she would be in – the answers from her husband and step-father were unsure.

Holly felt more should have been done at A&E, where her blood pressure was recorded and a venous blood sample taken, namely in terms of providing information about the physical processes she was potentially awaiting: “[the] A&E department could of given me some advice, rather than just ‘go away, come back in four days’”. Feeling the resources and spaces of ‘traditional’ Western medical knowledge were unable or unwilling to inform her, Holly searched online for stories of personal experience. However, she felt that the National Health Service (NHS) should be “the ones offering concrete advice and support and you *shouldn’t have to* trawl the Internet for stories about what people have been through”. A particularly undesirable outcome of this was coming across “horrendous horror stories, you can get horrible long term complications that you hear about because one person’s had it and they’ve posted online and it’s scary, it’s really scary”. Equally, though, Holly felt the NHS Direct website underplayed miscarriage “to hear you might get a bit of spotting and a bit of cramping, it’s just utter rubbish in comparison to what happens”. This contrasted sharply with an online video Holly found of a woman discussing her late (21 weeks) miscarriage: “it’s almost false to [...] use that as a good example of a, of most people’s experience”. Holly suggested, then, that there is a lack of information specifically about miscarriages towards the end of the first trimester. The video also impacted on her subsequent pregnancy: “THAT REALLY stuck in my head, that video, and when we got past 21 weeks with this baby – I felt MUCH better”.

The prospect and experience of miscarrying can be extremely frightening, compounded by a stark contradiction between lacking or withheld information about the physical processes of miscarriage alongside a necessity to monitor and act if/when the bleeding became ‘abnormal’ or dangerous. Holly conveyed the necessity of practical resources, information and emotional preparation in order to make informed decisions as to whether to seek further medical assistance:

I think you need to be prepared, you need to have painkillers and to know what you can take, what you can’t take, and being careful and looking after yourself and knowing what’s what, like if

something is wrong and what to do, like being able to spot if you're bleeding too much or... I just don't think there's enough information [...] being told 'if you're soaking through [menstrual towels quickly] blah blah blah after five days, go to hospital' but I'm sorry – if you've been bleeding that heavily for five days you've lost far too much blood.

There can be reasons why one would not wish to return to A&E; indeed, Holly herself resisted the suggestion from her husband, concerned that there might be “something seriously wrong” regarding the extent of pain, on several occasions in the following days. The emotional upset of being largely ignored and asked ‘intrusive’ questions about her bodily processes in the public reception was a key disincentive for returning to A&E:

the thought of being in A&E while miscarrying – argh, it's just horrendous. I imagine that a lot of women get terrified by it, I mean I was really scared, it was horrible, and that's WITH having somebody [my husband, a GP] there who knows what to do and is kind of very calm and helping me as much as he possibly could, if anyone's doing that on their own – that's just... and I think that's really wrong, they [the NHS] should be able to offer you more than that.

Such an account resonates with the arguments made by Murphy and Philpin (2010) regarding lacking and inadequate attendance to (and, Holly felt, information about) the physicality of miscarriage. Holly recognised that some women may not wish to know but that “people should probably have the ability to get hold of that information”. The dearth of appropriate information, confounded by reluctance from close family members to elaborate on knowledge they deemed too sensitive or graphic, caused Holly a great deal of distress. One aspect of this pertained to the fact that she had internalised the imperative that she must monitor her bleeding but, in practice, would have to do so in the absence of certainty regarding the distinction between ‘normal’ and ‘dangerous’.

Many participants spoke openly about their experiences of pregnancy loss, including the physical and more ‘taboo’ aspects. For instance, Carla was not reticent in her descriptions of bleeding, labour/birth and post-delivery

(un)healing, and at times seemed to take pride in her capacity to stomach what she acknowledged as potentially gruesome. On one occasion, after vividly recounting the ripping of her post-delivery stitches when the dried blood bonded with the material of a sanitary pad, she even joked “you look like you’re going to be sick!” Carla, summarising her reproductive past as “if I actually thought about it – I would scream”, described two miscarriages and three terminations in addition to the birth of her (living) son. Subsequently, blood loss featured in her account in a number of ways and in relation to a number of scenarios, but it is her most recent medically induced termination in particular that I will focus on here. Carla explained that she had taken the first stage pregnancy-ceasing pill but bleeding had still not begun five days later. She returned to the clinic where she was told to keep walking to stimulate bleeding and Carla was then driven home by her mother:

[when I] got in the car to go home, everything [was] fine, it was like ‘you alright?’, ‘yeah’, and I half fell asleep, stood up at my house to get out the car, I stood up and I’ve never had such blood gush out of me [...] my trainers – I had to throw out ‘cos they were covered in blood.

Her bleeding continued for three weeks with a significant number of large ‘clots’, regarding which she “ended up actually going to the doctors to say ‘is this normal?’ because it’s loads and I don’t know why [...] I was so scared”. Comparing it to her normally very heavy periods, Carla managed this extended bleeding and felt reassured by the doctor that the clots described were normal.

However, it was clear that the initial “gush” of blood had been troubling for Carla not only because of the unexpected quantity/velocity of blood flow, but also owing to its public presence. Relating to notions of stigma (Goffman 1963) and cultural understanding of uterine menstrual blood (Shail 2007; Meyer 2005; Vostral 2005), the visibility of this was something that Carla felt an imperative to ‘contain’ or, given the street setting, at least dilute:

my trainers were covered in blood, there was a pool of blood outside the house – it was just like ‘shit’, we had to get a bucket and wash it away in case people saw, and it was just, like,

everywhere at home, in the shower, and I was just, like, there was a blood trail through the house that we had to clean up.

Whilst uterine blood is an abject fluid that can provoke sentiments of death and dirt, the specific socio-emotional context of this instance made the need to ‘get rid’ of the pool of blood outside her home all the more pressing. The termination was an especially highly ambiguous endeavour for Carla, ending a pregnancy that had been part of her plans for a “nice little happy family” prior to the discovery of her partner’s adultery. As a result, she felt both sadness and a degree of relief from closure:

it was like thank fuck that’s over, let’s get back to having a normal life, with the last one it was like right that’s [ex-partner] wiped out my life forever which sounds horrible [...] but it was like now that’s done, dusted, gone, no more problems, I won’t have to see him, especially as I found out he was cheating, I couldn’t of coped.

The emotional intensity of Carla’s experiences of miscarriages and terminations emerged in poignant ways and yet it was also very clear from her narrative that she suppressed a wealth of very distressing experience. She openly stated the reasons behind her terminations, highlighting difficult life circumstances with her first termination occurring whilst she was under the legal age of consent for sexual intercourse and her second which had involved an unreported sexual assault. In contrast, the miscarriages were wanted pregnancies and at times when she felt emotionally, physically and financially able to support, and be supported within a relationship in raising, another child. Although I have spoken about the limitations of ‘choice’, this language was crucial to the ways in which Carla articulated the different endings of her pregnancies:

because terminations, they were my choice, where even if when I’ve been pregnant when I’ve had a miscarriage, it still should have been my choice as to whether I had a kid or had an abortion, whereas it wasn’t – the choice was removed.

Bleeding featured in these ‘choices’ also, implying that the bleeding of terminations was anticipated and weighed up against the ‘costs’ of remaining pregnant. Whilst the bleeding in miscarriages of wanted pregnancies was described as physically similar, these bodily experiences also entailed additional

aspects of sadness, confusion and disappointment – although Carla seemed resistant to dwelling on the emotional upset. This constituted a kind of guardedness and coping strategy, echoed in her assessment of the support advice she had found online:

[pregnancy loss support websites] go on about how you should be feeling, all *oh, you know, 'you should feel sad'*, BUT, they don't tell you anything about the fact that sometimes you just want to pretend it hasn't happened and ignore it, *oh 'you should take time off work'*, NO, if you wanna go back to work as soon as possible so you can forget this has ever happened in your life, do it; they don't give you that kind of advice, of get back to your normal life as soon as possible, which is the best advice I could ever give anyone.

Reiterating earlier discussions from both Chapter 4 and the Methodology, a helpful approach or comment for one person who experiences pregnancy loss may not be deemed as such by another (see also Chapter 6).

Bodily Fluids Beyond Blood

Encounters with particular bodily fluids like breast milk had been anticipated by some participants under very different circumstances and emotional expectations. Whilst the painful schism between anticipated tears of joy with actualised tears of sadness in pregnancy loss is one such example, focus in the remainder of this section will be on the topic of onset lactation following late losses. Such an example entails connections between bodily experience as the flesh swells and internally aches with colostrum and milk, exiting the ducts from 'inside' to 'outside' of/upon the skin, prompted by the movement and delivery of foetus 'inside' to baby 'outside' the body. The fluid of breast milk and the physical experiences of this leaking or flowing out of the body were described by some participants as illustrating or amplifying their emotional losses, as well as the physical/physiological losses, in particularly distressing ways. The viscerally felt and visible presence of leaking milk post-pregnancy loss highlights a disjuncture between the anticipated biological function (to feed a living new-born) and particular reality (with no living new-born to feed). That is, the presence of milk/lactation forcibly demonstrates an absence of neonatal

life to care for and can reiterate the disjuncture between anticipation/hopes (of the past) with pregnancy loss realities.

Anne described how her bodily processes, such as post-delivery healing and the production of breast milk, continued to occur without recognition that her pregnancy had ended at full term in stillbirth. She drew on information from online pregnancy loss support groups signposted to whilst she was in hospital and from her community midwife who visited to check her stitches and “help with concerns such as the fact that my milk came in, that was incredibly distressing and stuff so, she came for that kind of support”. These two sources of support for Anne could offset one another’s limitations since booking appointments with the community midwife meant delays whilst the support groups were attributed limited medical legitimacy; they could, as in this case, also validate recommendations:

there was a couple of different [online group] boards and I posted and I asked about my milk coming in and how I could stop it because I wasn’t seeing my midwife for a couple of days and she [the midwife] told me to ring her at any time, she was just absolutely wonderful, but I just didn’t want to, or I wanted to talk to other people about their experiences and I went on and they gave me some advice erm which a couple of days [later] was the same advice the midwife gave me.

Anne recalled the physical pain of onset lactation about three days after her stillbirth: “my boobs really started hurting, they went rock hard, they looked absolutely massive and they really REALLY hurt”. Anne followed the advice from the online group, subsequently reiterated by her midwife, to “wear a tight bra all the time, morning, you know, daytime and night, sleep with a tight bra on all the time, don’t touch your boobs at all, put breast pads on in case you get any leaking”. Anne described how she was:

incredibly distressed, I was hugely worried about seeing the milk because it just seems INCREDIBLY cruel that your body still does those things when there’s no baby, when there’s no baby to actually and I’d been planning on breast feeding so when there’s no baby to actually do that with and yet my milk was still coming

in, it just felt all wrong so I was quite... lucky that it just, you know, after a week went away basically.³⁰

Gemma also commented on the emotionality of onset lactation as interplay between grief following loss and ‘normal’ physiological/hormonal responses:

it’s hard to say what’s physical and what’s mental really, I mean, you always have a hormonal change at three days after delivery with a natural birth but there’s kind of... you know, breastfeeding and kind of, they call it the baby blues at day three, yeah, that’s normal. I think it was day three when I was just kind of... numb really and I can remember just crying and then feeling okay for half an hour and then feeling, just crying for half an hour, you know, I couldn’t, it was just the first time I’d ever experienced grief like that {inhales deeply} and I can always remember the boobs {laughs} I had these rock hard, massive boobs that were desperate to feed a baby and they were kind of leaking quite a lot so that was hard to deal with.

Additionally, the practical responses to and management of the onset of lactation without a living new-born to feed can entail entering spaces and situations where this disjuncture is again reiterated. Gemma explained that “we had to go and buy breast pads which again is like you’re buying all this stuff in the maternity section of Boots or whatever and it’s next to the nappies and you kind of, all that stuff I remember being a bit difficult”. The onset of lactation and its implications can therefore reinforce the schism between expectations/wishes for a healthy, living baby and actual outcomes of pregnancy loss, prompting the “deep emotional anguish” (Doss 2010 p80) of grief.

Foetal Materiality in Early Pregnancy Losses

In addition to bleeding and pain as ‘first signs and confirmation’ of early miscarriage, Murphy and Philpin (2010) identify the topic of ‘losing the baby’.

³⁰ The desire for cessation of lactation is not the only form of response/management and, in Giles (2003), Shelley Abbott provides an account of the death of her infant daughter following which she continued donations to a milk bank. She is quoted in Giles (2003 p58) saying that this “gave me a kind of hope, something positive to look at, I guess. I knew I was giving a gift, so I didn’t feel so sad, or distraught, as I knew my milk was going to somebody”.

Sometimes, as in early miscarriages when the embryo may not be identifiable, the blood was seen as synonymous with the embryo/‘baby’ of pregnancy loss.³¹ Different ‘textures’ and ‘features’ of the uterine blood were mentioned, with viscosity and clots, accompanied by strong emotional reactions like distress and aversion, contrasted to the women’s ‘normal’ menstrual flows. Whilst early miscarriage bleeding can seem a particularly exaggerated form of menstruation, the inclusion of embryonic or foetal materiality—whether visibly seen or not—renders it particularly distressing (Murphy and Philpin 2010). Though it may be identifiable to the trained eye of doctors and nurses who encounter miscarriage frequently and are skilled in ascertaining this information (Murphy and Philpin 2010), many of the women in my research who had early miscarriages were unsure about distinguishing between the ‘general’ endometrium blood and pregnancy materiality. In contrast to the shadowy images of ultrasonography which, in the contemporary era, “we see what we are shown” (Duden 1993 p17), most people cannot easily ‘read’ early miscarriage uterine bleeding for such distinctions.³² Subsequently, for many of my research participants also, there is often a “tension between their actual physical experience of passing blood clots, fragments of tissue, gestational sacs [...] and their conceptualisation of their pregnancy as a baby” (Murphy and Philpin 2010 p538).

Early miscarriages are atypical bereavements since there is often no coherently identifiable or otherwise tangible body (Murphy and Philpin 2010). Ambiguities regarding bodily encounters with blood emerged in efforts to decipher distinctions in/constituting blood flows (liquids, clots and embryonic entities). Many of the women’s early miscarriages entailed a ‘mix’ of bloods across time in terms of consistency and colour. Marie explained about her second pregnancy loss of three miscarriages in total: “I went to the toilet upstairs unaware of a problem and it was only when I wiped that there was bright red blood on the tissue. I panicked, I wiped again and it was there again”. She visited A&E before returning home where the bleeding and cramping

³¹ First trimester miscarriages are focused on in this section since, in these, the significance of blood ‘with’/‘containing’ embryo and placental material was emphasised whereas later pregnancy losses entailed encounters with more recognisable foetal/baby bodies.

³² A few of the women in the research were themselves medically-trained such as Beth who was able to, but dreaded the prospect that she might, identify such distinctions in the materiality passed.

worsened and, by the evening, she “was passing what looked like tissue and I knew then it was all over. My heart sank and I felt so upset to have to go through it all over again”. Marie’s first miscarriage had been managed surgically and this was also the case for her third miscarriage after the bleeding in her second had been very heavy and extended across a significant period of time. The second miscarriage bleeding experience had also entailed encountering ambiguous materialities, as she was “passing tissue and passing clots and passing lumps of bits and pieces of what was left of the pregnancy and more bleeding”. Marie summarised her experiences of her ‘natural’ miscarriage:

I carried on bleeding heavy for that week and the following week, by which point I was passing liver type tissue. I had to ring the hospital at this point to give them an update of the bleeding to make sure all was "going OK" they were happy with what I had passed and how things were going and that was that. I carried on bleeding off and on, mainly red blood, for the whole of May. It stopped for a few days towards the end of the month and I thought it was all over, but then I started bleeding again after maybe 3 bleed free days and I then bled for a further week. [...] It made me realise that I was glad that I had opted for a D&C in [the first miscarriage] as the natural miscarriage went on for weeks feeling much more drawn out.

Marie described the physical experience of her natural miscarriage as “more uncomfortable” and emotionally painful: “every time I saw the blood it was a constant reminder of me losing our baby”. This contrasted to the surgical management which she “felt [was] over with much quicker as the bleeding was a lot less and mainly brown”.

Additionally, echoing Holly’s earlier comments, Marie received much less information in relation to the natural miscarriage as to what might indicate a problem/danger with bleeding in contrast to the medical support and information for her D&Cs. Marie was aware that the extended and extensive bleeding in her natural miscarriage may have been because she had not “pass[ed] everything” initially and, aware that this could pose an infection risk, she checked her blood “just to make sure there was nothing funny about it, it didn’t look or smell really horrible or wasn’t uncomfortable”. In doing so, she

encountered ambiguous matter: “a tiny bit of... it wasn’t a clot and it wasn’t just blood, I think it was a tiny, tiny bit of tissue that was a little bit of a red tinge”. These experiences were so upsetting that Marie “was more determined to have another D&C” after the diagnosis of her third (missed) miscarriage because “I really didn’t want to go through another natural miscarriage as this time there would be more to pass than before [as the pregnancy had continued for longer] and I didn’t want to go through all the pain, discomfort and seeing my baby”. She elaborated on this latter aspect, saying “I couldn’t bear the thought again of having my dead baby inside me I wanted it taken away as it was too upsetting” – a topic which I will elaborate on further shortly.

In addition to the striking visibility of blood and additional distress of seeing foetal tissue, some participants described the physical sensations of foetal tissue that had been/was being expelled. As mentioned in Chapter 3 and forthcoming in Chapter 7, this resonates with Colls’ (2012) discussion of ‘intra-touch’ and forms of touch which cannot be seen. The conceptual significance of vaginal lips (Irigaray 2004) has been utilised by feminist geographers such as Colls (2012), Straughan (2012) and Cant (2012) to challenge the (masculinist) insistence on space as separation and gap, instead emphasising touch (Paterson *et al* 2012). Linking to this, some participants’ encounters with foetal materiality, and potentially the moment of ‘definite’ pregnancy loss, were identifiable though intra-bodily (vulva and labia) touch. The sensation of *feeling* prior to seeing foetal materiality as it moved/had moved out of the body and, for example, onto underwear or toilet paper, emerged in a number of participants narratives. Holly described an abject sensation which characterised a specific moment in which a foetal entity (as separate to/from her) was encountered through touch (rather than initially through sight). She explained:

when I woke up I could feel that there was... something in my knickers and there was blood everywhere and I knew that if I moved there was going to be blood everywhere, so I just lay there for a while and [my husband] was not really asleep but I wanted to let him sleep a bit longer, erm... and eventually I said, I woke him up and said ‘I have to go to the bathroom and you’re going to have to help me’ erm... and I just didn’t want to look, awrrrr, horrible, I really didn’t want to look but it feels... it just felt like... a lump [...]

and blood running down my legs and the pain was pretty much gone by then, it was just cramps [...] I was like waddling to the bathroom and he [my husband], bless him, he just... I was completely numb by that point and just sat there and he sorted it all out and we both looked at it and it was like this little golf ball sized... thing. Erm... and lots of blood.

Distinctions between blood, clots and embryonic/foetal matter had emotional and practical implications, such as in relation to degrees of handling and the locations deemed 'preferable' for these entities to reside. Murphy and Philpin's (2010) research included a woman who took care not to 'pass' the materiality of the 'baby' into the toilet and instead into her hand. For some of my participants, the prospect or actuality of the embryonic/foetal matter being in the toilet bowl or bin was also particularly upsetting and could induce feelings of guilt and remorse. This topic formed part of an email interview exchange with Fiona after I asked her what she did following her experience of heavy bleeding, intense pain and the felt movement sensation of passing matter:

I'm trying to write it as just facts but in truth the feeling of shame gets me here. Exactly after the miscarriage happened, when I had ran to the bathroom and seen what was there on the [sanitary] towel, I remember just sitting there for ten minutes looking at it, just trying to process it. It was that sensation of not really believing what your eyes were telling you, that you're trying to think of something else that it must be, that it had to be something else because the thought of it actually being a baby was too difficult and painful to even begin to comprehend. So you can imagine the frame of mind I was in. My first thoughts were 'I can't leave it sitting around'[,] it was bad enough that I had to see it let alone show it to anyone else or have my two year old walk in and see it [...] I was at a total loss at what to do, I ended up wrapping the whole thing ([sanitary] towel included) in tissue and I put it in the bin. Sorry even just writing that makes me so angry at myself.

In my email reply, I sought to offer reassurance to Fiona that she was not alone in having done so and reiterated my own views that there is very little guidance or alternative options regarding what to do in such a confusing, potentially

emotionally overwhelming situation.³³ With relevance to earlier discussions in the Methodology, this seemed to provide some consolation; Fiona replied:

I've never told anyone before (mostly because of the fact that I feel I'd be judged for it, little does anyone know how much we judge ourselves for it)[.] Even just trying to respond to that question in the last email made me quite anxious about it, because to be truthful it does make me feel like some sort of a monster, but to hear that someone else has also experienced it too, it does help, more than I could ever say. So thank you Abi.

Across different accounts of the physiological experiences of uterine bleeding and encountering 'foetal' bodies in early- miscarriages and terminations, there emerged tensions between respect-love and repulsion-abjection. This, I suggest, relates to the ambiguous status of foetal materiality as betwixt-and-between menstrual blood and bodies of deceased loved ones. Worden (1993) suggests that the bereaved can benefit from seeing the body of a deceased person they knew, to process the reality of the death, in—for instance—a funeral home or mortuary, but should be informed if they body is 'mutilated' (from autopsy or if the cause of the death had been violent). As mentioned, there has been much debate regarding the impacts on parents seeing/touching their stillborn children with recognition that this can be, depending on various aspects, traumatic for some but beneficial and valued by others (Rådestad *et al* 2009). One factor in this involves carefully preparing women for what to expect after birth in order to minimise unwarranted fears or discomforts (Trulsson and Rådestad 2004; Rådestad *et al* 2009). Participants in my research had often been very unsure about what to expect in early miscarriage and about what they might see in/from their blood. In relation to wanted pregnancies, including retrospectively so if pregnancy had been unknown prior to loss, participants often reiterated the sharp contrast between hopes and expectations for a child and their actual encounters.

Emphasising that 'death' must be recognised as entailing multiple aspects rather than being treated as monolithic in 'taboo' debates, Woodthorpe

³³ This is supported by a number of participants and, as Fiona later said, "no one ever teaches you how to react in those situations, I mean what are you supposed to do in that event? Put it in a plastic container?" The theme of interment will also be explored in Chapter 8.

(2010) highlights the widespread discomfort in thinking and talking about the materiality of the dead body, including disposal and decay. The notion that the dead body is the primary example of abjection 'waste' (Kristeva 1982), with deceased babies especially so (Minogue and Palmer 2006), pertains not only to its status as 'matter out of place' (Murphy and Philpin 2010) but also issues of temporality. As Komaromy (2000 p305) argues, "the body immediately after death is more than death embodied, it has an ambiguity that is also temporal, in that yesterday it was alive and today it is dead". Thus a 'baby' deceased before birth, as in miscarriages and pre-partum stillbirths, confounds normative cultural notions of the linear temporality of 'life'. Fiona's description of her experience, accompanied by self-scolding since her miscarriage several years earlier, conveyed some of these tensions between care and aversion:

the remains looked nothing like you'd expect, they looked nothing like a baby, (Maybe I was naive, but beforehand I always assumed that if you were to ever see something like that, that it would actually look like a baby) [...] I feel ashamed at that [putting the remains in the bin], at the fact that's where our 'baby' ended up.

This resonates strongly with Murphy and Philpin's (2010 p538) comments that uncertainties and ambiguities as to 'what' is encountered in early miscarriages by the women were "reflected in the words they used to describe their pregnancy as they revealed a mixed picture in the words used to talk about what had been lost". For instance, Fiona described uncertainty as to what she should/could have done with "it" in her bathroom and that "afterwards, [I felt] the guilt, the shame of knowing that, of knowing it was a baby, a life... it's still a lot to take in at times". There are clear links with the observations of Murphy and Philpin (2010 p538) who describe how the women in their research also "oscillated between using impersonal terms such as 'it', technical terms such as 'foetus' and 'embryo' and terms such as 'baby' and 'child'".

Implications for the 'Geographies of Death and Dying'

Attending to the encountered bodily fluids and flows of pregnancy losses has implications for the 'geographies of death and dying' in highlighting spaces not usually considered within this remit. The 'geographies of death and dying' can be understood as a sub-discipline attending to and, within the broader

scope of ‘death studies’, inviting recognition of a plethora of locations concerning themes of grief, dying, death, bereavement and loss. As Hockey *et al* (2010) note in the introduction to an edited collection, this includes—amongst others—spaces of death and/or forthcoming death such as cemeteries, funeral parlours, hospices and hospitals (of which sub-spaces can be identified, such as the resuscitation ward – Page 2010). Additionally, research on memorial benches (Maddrell 2009b; Wylie 2009), tended/decorated graves (Francis *et al* 2005), trees (Cloke and Pawson 2008), monuments (Junge 1999; Doss 2002, 2010; Sargin 2004), cairns (Maddrell 2009a), displays/exhibitions (such as the NAMES project AIDS quilt – Lewis and Fraser 1996; Brown 1997; Brouwer 1998; Junge 1999; Doss 2010) and spontaneous memorial sites (Foote and Grider 2010; Maddrell 2010; Doss 2002; Phelps 1998; Azaryahu 1996) have foregrounded the importance of space in relation to responses by those bereaved.³⁴ The predominant empirical examples in the ‘geographies of death and dying’ and more generally in ‘death studies’ have tended to privilege normative notions of whom dies, with a focus on those recognisably adults or children, with implications for understandings of ‘where’ dying, death, mourning and memorialisation are seen to take place. As stated in the introduction, it seems pregnancy losses have been largely socially, medically and academically ‘silenced’, constituting forms of ‘disenfranchised grief’ (Doka 2002). Subsequently, pregnancy losses risk exclusion from being seen as relevant for consideration since the ‘whom’ or ‘what’ are more ambiguous and contested.³⁵

Legally in the UK, as of 1992, stillbirths are recognised from 24 weeks gestation and are issued with death certificates, whilst earlier forms such as miscarriages tend to be deemed less significant and not ‘deaths’. However, outside of the legal definition, some women (and their families) do understand their earlier pregnancy losses to constitute forms of death. This issue concerns

³⁴ In addition, to the spaces at which deaths- and/or responses by the bereaved- occur, the concept of ‘consolation-scapes’ (Venbrux and Jedan, forthcoming; following a four-part session at the Emotional Geographies 2013 conference) signals a growing attendance within geography to the spaces involved in responding to the bereaved.

³⁵ This is not to discount work which does indeed engage with spatiality and some kinds of pregnancy losses in particular contexts, such as Bleyen (2012, 2010) on stillbirth historically in the Flemish context and Woodthorpe (2012) on baby gardens in UK cemeteries.

questions of where and when ‘life’ begins. Whilst for some, “the moment of conception represents the coming into being of a new human individual” (Franklin 1999 p69) – for others, the logic is that ‘arrival’ into ‘life’ of a person is marked by birth and post-partum breath.³⁶ The latter dominant logic holds that deaths *before* births are not really deaths at all since no ‘person’ yet existed in terms of independently breathing. Subsequently, claims to having one’s grief recognised are rendered unstable and illegitimate, with mourning and memorialisation practices often deemed excessive and unrequited by social others who have diverging interpretations of the significance of the events. As evidenced in the notion that death occurs when “[t]he body that sustained itself, whether for a few hours or the lifetime of a long marriage, is now unsustainable” (Hockey *et al* 2010 p10), normative understandings of death require the subject of loss to meet particular biological and post-partum criteria.

Regardless of medical, legal or otherwise understandings of where ‘life’ and therefore ‘death’ can be attributed, some persons within the research regarded their early pregnancy losses as deaths and bereavements. Of course, pertaining to the complex issues of reproductive politics, it should be emphasised that this view/vocabulary use is not universally the case for all who experience pregnancy losses (Kevin 2011). However, in addition to some of the aforementioned comments by Marie (this chapter) and Tessa (Chapter 4), several other participants (Helen, Tania, Caroline, Diane and Penny) used the vocabulary of death in describing their encounters with embryonic/foetal materiality either directly or as mediated through ultrasonography scans. Exemplifying this alongside a sense of uncertainty conveyed through her language use (Murphy and Philpin 2010), Holly reflected on her miscarriage:

I don’t know whether I thought of it as MY BABY or whether I thought of it as this thing, this dead thing, I think I probably thought of it more as this dead thing and it’s horrible to think of a dead... tiny... thing... inside you and about to come out.

This was one evident way in which “[t]here is an aura of uncertainty around” the events of pregnancy losses (Frost *et al* 2007). As is foregrounded throughout my

³⁶ It should be noted that this is not unanimously agreed upon; hence, even for neonatal deaths in which a baby survived after birth for potentially several hours, days or weeks, social others may refute recognition that this counts as having really been ‘alive’ and thus having died.

research, different meanings of the word 'loss' can include aspects of materialities, possibilities, imagined futures and/or refer to events of death.

Ambiguity is widespread as to the experiences of bodily flows in which uterine bleeding—involving matter which is inanimate/not alive but has previously been or may have been thought of as animate/alive—can be understood as betwixt-and-between that of menstruation and corpses. It is evident that, for some participants, their pregnancies involved a person or forthcoming person. Duden (1993 p107) argues that contemporary discourses of pregnancy, with conceptions detected with urine tests (Chapter 3) at ever earlier points, underpin the “acquisition of a new consciousness” for pregnant women. Duden (1993 p109) argues that efforts are made to impute meaning by transforming “the dynamic equilibrium of that open process into a “something.” [...] [such as by naming] the cybernetic process “a life””. Subsequently, it can be understood that particular activities produce social identities for the ‘expected child’ and are supported by this orientation towards pregnancy. Embryos and foetuses are relationally rendered meaningful as ‘babies’ (or not) with others and within particular socio-political contexts (Morgan 1996). ‘Realness’ is produced with “each cup of coffee or glass of wine abstained from, and each person informed of the impending birth” (Layne 2000 p322) and “family lives are dreamed into being” (Hockey and Draper 2005 p54). Activities like decorating the nursery and choosing names are “inherently social”, largely accepted by social circles in anticipation of (live) birth (Murphy 2012a p126). Pregnancy losses disrupt the linear trajectory in which a living child is anticipated to occupy the social identity produced for it. In early pregnancy losses, blood-body fluids and matter are instead encountered alongside the emotional distress of ended (or altered) anticipated hopes, dreams and futures.

The dead body occupies a powerful position in contemporary society, provoking grief but also abjection, anxiety and fear (Hockey *et al* 2010; Valentine 2008). Worden’s (1993) suggestions that the bereaved view the (normative adult/child) deceased body concern particular places of encounter. Funeral parlours, Hallam *et al* (1999) demonstrate, are spaces at which work is undertaken to restore/cosmetically fashion the corpse in order to manage the responses of the bereaved to viewing to minimise aversion by seeking to reflect the person that was, potentially including details such as the deceased’s glasses

for the final viewing and/or burial (Harper 2012). As an example of the institutional sequestration of death (Fowler 2004), the spaces of funeral parlours enable funeral directors to present themselves as not merely 'selling' a funeral but as facilitators of grief work (Ariès 1976). Encouragements such as Worden's (1993) thus refer to the professional funeral industry which itself can play a part in legitimising, along with medical and legal definitions, the grounds of 'normative deaths'. Such a carefully managed, aesthetically sanitised, professional environment scenario is often not the case for pregnancy losses, especially in relation to early miscarriages. The locations in which women and potentially their partners, like Holly's husband, encounter the ambiguous blood-body matter include the spaces of bathrooms and toilets. These are important locations for discovering, checking/monitoring and therefore encountering uterine blood loss and potential pregnancy remains in addition to being potentially amenable spaces for emotional support (as mentioned in Chapter 4).

Whilst the toilet may be deemed the preferable location for the containment and disposal of bodily fluids like menstrual blood, pregnancy loss uterine bleeding can occupy a more complex position. As Martin (1987) skilfully demonstrates, menstrual fluids tend to be equated with 'waste' and thus this form of bleeding tends to be seen as appropriately disposed of instantaneously (with modern toilet systems) in order to preserve the 'civilised' self. However, as Fiona implied, when the uterine bleeding pertains to early pregnancy loss and contains (whether visibly/recognisably so or not) material which is ambiguously or certified to be bodily matter of the 'deceased', the toilet or bathroom bin can be seen as an unsuitable, even disrespectful, location in line with social conventions for the 'respectful' treatment of corpses. The blood flow, containing matter, of early pregnancy losses can thus occupy a position betwixt-and-between menstrual 'waste' and bodies of the deceased. To return to the topic of social- and biological- life and death, this highlights that there is diverging consensus regarding what qualifies as a 'dead' body, given that "[f]lesh is variously read; variously attributed with the status 'alive' or 'dead'" (Hallam *et al* 1999 p81). For participants whose pregnancy losses were not legally classified as 'deaths' yet nonetheless experienced their pregnancy losses as these, uterine blood fluid and flow may be explicitly or implicitly understood to constitute or contain the materiality of the dying and deceased.

Additionally, as conveyed in the quote by Holly earlier, the very pregnancy-losing bodies of women can be seen as sites in which processes of dying and death occur in contrast to normative deaths as bodily detached/separate events, with the option to travel to a funeral parlour or mortuary to see or touch the dead body. Helen explained that “you want to know if there is a dead baby inside you, no matter the stage of pregnancy” and Caroline stated:

I'll never forget it, thinking oh god I've got this poor dead baby inside me and trying to be chirpy for my two children and I went back on the Monday to A&E and begged please, please, you know, please sort this out now, I can't walk around like this.

My discussion of uterine bleeding in early pregnancy loss highlights the toilet/bathroom as an example of the kinds of spaces brought into view when an expanded (but not totalising) scope of the ‘geographies of death and dying’ remit is utilised. By engaging with pregnancy losses, taken for granted notions about who/what dies, where death occurs and how this can matter are exposed – subject to further examination, particularly with regards to termination debates (Kevin 2011), and elaboration. As discussed in Chapter 3, I argue that this can also include ultrasonography spaces, waiting rooms and the circulation of such medical technologies (visually and/or audibly as ultrasonography images, videos and sound clips) which extend into ‘everyday’ spaces such as one’s living room (via TV) and cafés (via mobile phone technology). The spaces of toilets and their entailed practices have been arguably under-researched in the discipline of geography and social sciences overall (Dodge and Kitchin 2012; Schapper 2012). However, these are important locations in some pregnancy losses experiences—as sites where uterine bleeding is often detected and continues to be monitored or observed, sometimes over extensive periods of time—in distressing, frightening and otherwise intensely emotional ways.

Concluding Remarks

In this chapter, the presence and/or prospect of blood has been shown as relating to decision-making, such as around miscarriage management options, and to convey different meanings including that of forthcoming/confirmed pregnancy loss and fear for one’s own health with haemorrhage or infection. With a range of responses to pregnancy losses possible (Reagan 2003; Keane

2009), the emotional aspects of the discussed examples have included sadness, grief, embarrassment, relief (as in Carla's termination) and abjection/horror. I have re-focused attention onto aspects of pregnancy loss experiences which, owing to taboos and social prohibitions around bodily fluids, are otherwise often 'missed out' of or framed as background information in the relevant scholarship. The example of uterine blood loss highlights this flow/fluid as simultaneously physiological and thus of medical interest but also with significant social and emotional implications and therefore pertinent to social science and humanities research. Pregnancy losses challenge a neat separation of 'mental' and 'physical' health, instead demanding the recognition of interplay between the biological and social, material and emotional, bodily and cognitive. Additionally, as I have argued, attending to the topic of bodily fluids and flows in pregnancy loss highlights a range of emotionally-imbued spaces, such as bathrooms and toilets, pertinent to the 'geographies of death and dying'.

The conviction of participants about the inadequacy of information on blood loss and pain received from medical staff was often supplemented by searching for information and discussion online as well as through personal networks of friends/family. Crucial to this dissatisfaction was the view that the advice about 'what to expect' was both frighteningly serious and yet vague or otherwise unclear. Many of the women spoken to had not felt informed about the extent of amplitude, longitude nor intensity of bleeding and pain with an uncertainty as to what constituted 'too much' and therefore presented a potentially urgent medical crisis for their own lives. Subsequently, not knowing where the line between normal and abnormal or acceptable and dangerous was, many women (and their partners and/or families) contended with a significant degree of uncertainty and anxiety. The uterine blood encountered was sometimes monitored or examined by the women themselves in terms of quantity, duration, colour, smell, felt sensation and texture/consistency, with the identification and handling of embryonic/foetal matter emerging as particularly ambivalent yet significant theme for many participants.

In addition to medical information, a perceived lack of emotional support expected (or hoped for) from medical staff was described by some participants, somewhat contradicting Murphy and Philpin's (2010) findings that nurses tend to focus on emotional support to the detriment of physical manifestations of

early miscarriages.³⁷ For example, Helen recounted being given verbal information about the medical management of miscarriage by a registrar who was “very matter of fact, nice enough but I can’t say I engaged with him”:

[a]fter he left, I popped to the toilet and when I came back there was a leaflet about the [M]iscarriage Association left on the bed. It was good to be given this but really, I wanted a friendly and understanding nurse to talk to me about how I felt about it all. I am not the sort of person to call an organisation and declare I was upset – but I did want to talk about it.

Leaflets can be an appreciated provision to supplement verbal information, but one which cannot be a substitute for real-time ‘in-house’ emotional support.³⁸ For Helen, being signposted by a deposited leaflet to charity organisations for emotional support was insufficient. Indeed, after her second miscarriage at 20 weeks, Isabel “felt as if I should be talking to someone about what had happened [...] but I was reluctant to contact anyone because I didn’t want to be a burden and waste their time”. Subsequently, some participants—either out of dissatisfaction with, or to augment, information and support received from medical staff as well as social others—turned to the Internet. These virtual settings can provide opportunities to engage in mutual support and consolation in contrast to the silencing dismissal of wider society. Particular bodily aspects usually considered ‘private’ can be ‘shared’ online in various ways (Longhurst 2009). In Chapter 6, I will now consider participants’ engagements with online support groups and, in particular, highlight some of the tensions and differentiations involved amongst multiple users.

³⁷ Disappointment with medical staff was not unanimously described. Jane, herself a medical worker, felt “uneasy” about online support group discussions “over bad hospital care [...] because I feel that all hospital workers do their best for their patients”. Some participants expressed appreciation for specific caring gestures from medical staff encountered. For instance, Tessa was “trembling uncontrollably” before her D&C when her gynaecologist “put his hand on my shoulder [...] it was a very reassuring touch”. Caroline also recounted an occasion when the surgeon performing her third D&C “knelt down in front of me, and he said ‘I am so sorry’ and... for me... {teariness} [...] it just meant so much... even 10 years later I still think [about that]”.

³⁸ Such leaflets were unevenly deployed across and within participants’ experiences; for example, Victoria was given two leaflets for her first miscarriage but none for her second which, after dismissive treatment by medical staff at an EPU, was then found to be an ectopic.

Chapter 6: Online, Pregnancy-loss ‘Support’ Groups

Introduction

Participants’ experiences of using the Internet for social, emotional and medical support and information highlighted notions of community and belonging but also the themes of stigma, exclusion and marginalisation. Kitchen (1998 p388, p393) posits that geographers are particularly well suited to consider the “complex spatiality of cyberspace”, attending to the “social, cultural and political implications” as well as the economic dimensions (also Dodge and Kitchen 2001). Relevant to my interests is academic work on computer-mediated support groups for health and reproduction, including that which has considered online pregnancy loss groups specifically (Gold *et al* 2012).³⁹ Across these contexts, online support groups have been associated with a range of ‘positive’ outcomes for users. For instance, Malik and Coulson (2008) identify several benefits of online infertility groups predominantly used by women pertaining to the ‘unique’ nature of being online such as relative anonymity, 24/7 access and convenience. Whilst Malik and Coulson (2008 p110, p112) recognise *some* “negative effects” for users, such as risks of becoming pre-occupied or overcome with distress and the potential for misunderstandings without verbal/body language cues, their participants may have been motivated to partake in their research precisely because of “particularly positive online experiences”, thus potentially underestimating disadvantages.

My interest in the online ‘terrain’ of pregnancy loss relates partly to the methodological underpinnings of this research, in which recruitment was facilitated through several online discussion groups and social network sites. 11 of the 24 research participants solely used email interviews with another four mixing email interviews with those face-to-face, telephone and/or Skype. All participants were computer literate to varying degrees and—given that recruitment posts were placed, and thus seen, on support groups—the vast majority disclosed having used/continuing to use the Internet in relation to

³⁹ The research on online support groups/communities includes those pertaining to: multiple sclerosis (Parr 2002); chronic illness (Crooks 2006); the Deaf community (Valentine and Skelton 2008); diabetes (Armstrong *et al* 2011); HIV/AIDS (Bar-Lev 2008); ‘problematic’ pregnancies including diagnosed foetal anomalies (Lowe *et al* (2009); infertility (Malik and Coulson 2008); and parenting/mothering (Madge and O’Connor 2002, 2005).

their pregnancy losses for information, support and/or buying memorial items.⁴⁰ For many participants, online activities such as searching for information and visiting support group sites formed part of their overall recounted experiences of pregnancy losses. Although Malik and Coulson's (2008) research included some 'lurkers' in online infertility groups, it seems that the wider scope of my pregnancy loss research—interested in topics other than online group usage—coupled with qualitative interviews, rather than online questionnaires, may have enabled the airing of some more overtly critical views about the online pregnancy loss support groups.⁴¹

Given that pregnancy losses are intensely corporeal experiences, I will provide an overview of geographical literatures tracing the overlapping relations between virtual spaces, 'real' spaces and bodily spaces (for example: Parr 2002; Madge and O'Connor 2005). Following this, I will consider the ways in which participants discussed using the Internet to seek information about pregnancy loss, linking to literatures about caution regarding the unregulated/unverified distribution of medical information online and challenges to the possession and scientific authority of medical knowledge (Broom 2005; Henwood *et al* 2003). Focus will turn to online pregnancy loss support groups/communities to consider how these can be "validating environment[s]" (Gold *et al* 2012 p70). I will then critically examine the validity of the label of 'support' in relation to a number of participants' ambivalences, reservations and/or responses of deliberate dis/non-engagement with the online groups for various reasons. As will be discussed, some of these views chime with my own concerns regarding the potential, "in the age of the public fetus" (Duden 1993 p55; Taylor 2004a, Lupton 2013), to cast further stigmatising lines of fracture and intolerance in relation to the topic of termination and other aspects of reproductive politics.

⁴⁰ In contrast to this, only a limited number of participants described: seeking 'hardcopy' information about pregnancy loss such as books from the library or requesting paper leaflets from organisations; knowing of and/or engaging with face-to-face or telephone based-pregnancy loss support groups; or having seen and/or bought items offline specifically described as pregnancy loss memorial objects.

⁴¹ 'Lurkers' in this context refer to those persons who view the online group interactions but do not themselves post or otherwise participate out of, for example, caution or cynicism.

Online Geographies and the ‘Online Terrain’ of Pregnancy Loss

In 1998, Kitchin stated that “we are still unsure as to the new spatialities which cyberspace instigates” (p399) and encouraged further research to examine the ways in which social relations are affected. In response to Kitchin’s (1998 p403) assertions that “geography remains paramount – cyberspace, rather than providing an alternative world, exists in a symbiotic relationship with real space”, works attending to themes of embodied experience have emerged (such as: Parr 2002; Madge and O’Connor 2005; Crooks 2006; Valentine and Skelton 2008) with particular relevance for thinking about the highly visceral nature of pregnancy losses. As Hine (2000 p114) highlights:

[r]ather than transcending time and space, as some theorists predicted, the Internet turns out to have multiple temporal and spatial orderings [... which] help to differentiate areas within the Internet and to make them meaningful as a set of social contexts.

A diverse array of cyberspace activities around pregnancy loss constitute an online ‘terrain’, including: information-seeking (via search engines, on specific sites such as NHS Direct, through support groups) about medical terms and services (like family planning clinics, the British Pregnancy Advisory Service); for support provision and reception (textually, including specific vocabularies such as ‘rainbow babies’ and ‘angel-versary’); commercial exchanges of memorial items (themed pin badges, teddies, bracelets and so on – often routinely ‘advertised’ on the forums as small businesses started/run by women who openly disclose having had pregnancy losses); online memorial sites (such as the ‘Forget-me-not meadow’ memorial page); campaign work (like organising/advertising for lobbying activities such as furthering research on stillbirth prevention and birth-death certificates); and sites concerned with religious evangelism or otherwise propagating pro-life views.⁴²

Echoing Denzin’s (2004) comments that online social researchers must be ‘bricoleurs’ in piecing together and adapting existing research methods, tools

⁴² These activities are not mutually exclusive to one another and may coexist on one webpage or in a series of different threads on a uniting website. Indeed, mourning and memorialisation can occur on ‘general’ websites and other media, as Walter (2011) considers in relation to celebrity deaths and online news websites.

and techniques, my research approach to online pregnancy loss support also entails bridging established understandings of ‘real world’ communities and communications with emerging explorations of these online. For instance, Layne’s (2003a) research on face-to-face pregnancy loss support groups highlights a number of ways in which such settings—purposefully facilitating the sharing of ‘similar’ experiences—can be beneficial: ‘breaking the silence’ by claiming pregnancy loss grief as legitimate and, subsequently, validating particular identities such as of ‘baby’ and of being a ‘real mother’. Subsequently, insights about face-to-face support groups are pertinent to some of the experiences expressed by my participants; however, whilst coexisting inter-relatedly on a continuum, online communications and spatialities can also differ from those offline (Kitchin 1998; Dodge and Kitchin 2001; Madge and O’Connor 2005; Valentine and Skelton 2008; Longhurst 2009). As conveyed in Madge and O’Connor’s (2005) hyphenated ‘cyber-space’, there are connections between ‘offline’ and ‘online’ lives and spaces: these are not radically distinct from one another but equally they are not the same and cannot be subsumed as identical. I mentioned some of these differences in the Methodology chapter, such as the ways that facial expressions are often ‘absent’ from written text yet can be conveyed and made apparent through emoticons or the narration of physical demeanour. Subsequently, online communication and communities can echo dimensions of offline support, such as emphasising emotional consolation, but not necessarily in a duplicate or straightforward manner.

Of particular interest in relation to the coexisting, interplay of different spaces has been scholarship (such as Parr 2002) responding to the earlier theorisations of the Internet as, firstly, entailing a near-complete transcendence of the physical body and, secondly, that such a state of existence would be desirable and liberating. From such a perspective, the Internet is deemed to offer the potential to efface the material identity/difference reference points of users, thus supposedly enabling opportunities to navigate around/away from identifiers which risk discriminatory (sexist, racist, homophobic) encounters. However, as Parr (2002 p76 *italics in original*) notes, far from the material body being disregarding in cyberspace, it can in fact be “*the cause or focus of travels in virtual worlds*”. In relation to pregnancy loss, this is indeed the case: participants often described browsing websites and/or posting on discussion groups to acquire information about their embodied processes *as they occurred*

(such as during uterine bleeding) or were *prospective* (as with different forms of miscarriage management: expectant/natural, surgical, medical). Additionally, evidenced by prominent social networking sites, many online activities and spaces continue to foreground personal identity in terms of visibility with profile pictures as well as in textual/auditory content.

In this way, it is clear that bodies are always present online, even if only by virtue of an embodied person positioned at a computer whilst viewing or contributing to websites and forum threads, and that “nobody lives only in cyberspace” (McGerty 2000 p89). However, Parr (2002 p75) argues that:

[i]t's relatively easy to begin to argue that the physical body is sometimes forgotten in virtual space, and seek to recall it as an academic project. It is less easy to understand how virtual space both enables a sense of technological disembodiment and yet simultaneously reconstitutes and reinforces the physical body.

As such, “[b]odies in virtual spaces are nothing if not complex” as they are “reasserted and reconfigured” within/through exchanges online, shaping not only how the bodily experiences of others are comprehended but potentially also informing how one’s own bodily experiences are understood and narrated by oneself (Parr 2002 p86). Subsequently, as Madge and O’Connor (2005) note in relation to discussion groups for parenting, there may be circumstances in which particular details deemed undesirable are omitted in the ‘performance’ of mothering online via talk and/or photo-sharing – yet key material, bodily aspects remain and in fact serve as the rationale of the group. That is, the existence of children and oneself as a ‘mother’ is not being denied but rather this embodied, lived context is utilised as the core unifying identity/theme of the group as (sometimes strategically with some omissions) conveyed in peer interactions (Madge and O’Connor 2005).

Likewise, pregnancy loss support groups exist precisely because of particular kinds of bodily experiences, thus refuting the assumption that the body is “irrelevant and invisible” online (Kitchin 1998 p80; Parr, 2002), even though the actual bodies of group users are not necessarily (visually, materially) evident to fellow users or observers. Bodily experiences, however, are represented in various (textual) ways and are subsequently reconfigured,

sometimes in relation to familiar objects and/or ways likely to be familiar to particular people as assumed shared references, such as between women and menses. Thus, akin to the use of comparative vegetables and fruit sizes during pregnancy to help conceptualise foetal development with Holly commenting about her 26 week pregnancy that “apparently it’s the size of a cucumber at the moment”, comparative reference points in both online and offline discussion can also be employed about the heaviness and rapidity of uterine bleeding.⁴³ For instance, Esther described: “I get heavy periods normally so that’s fine but this [miscarriage bleeding] was like nothing on this EARTH and to give you an idea I was shifting through the super thick sanitary towels in less than two hours”. Thus pregnant and pregnancy-losing bodies come to be textually, but sometimes visually via photographs/images, evoked presences online in ways which involve their bodies being “reasserted and reconfigured” (Parr 2002 p86).

Resonating with observations about online groups for infertility (Malik and Coulson 2008) and parenting (Madge and O’Connor 2005), Fox and Rainie (2000) argued that women use the Internet more frequently than men to seek health information. This likely pertains not only to the physiological centrality of women’s bodies in reproduction but also socio-cultural tendencies to be deemed primarily responsible for child-rearing and attending to the bodies of family/infants as well as their own (McKie *et al* 2004a, 2004b; Williams and Crooks 2008). Such practices participate in the wider performative ‘doing’ of family, with iterative processes of capturing, ordering, preserving, recalling and narrating family histories and futures in various ways (for example: Rose 2010 on family photos; Emslie *et al* 2003 on storying genetic inheritance). In addition, pregnant women—as well as women trying to conceive and providing postpartum care—are subject to a plethora of advice around, and coercion to monitor, their bodies.⁴⁴ ‘Disciplining’ reproductive bodies includes issues of: diet, cigarette/drug abstinence, ‘moderate’ exercise, submission to a range of

⁴³ Another example of comparisons with the size of familiar foods was Rosie, who described the changes regarding her diagnosed Polycystic Ovary Syndrome: “my ovaries were scanned at the beginning of IVF and were a bit like smooth almonds, the last scan I saw of them they were like a little bunch of grapes, so... they’re definitely getting more and more cysts on them”.

⁴⁴ This point also links to work looking at, for example, discourses around cervical cancer screening as an ‘embodied obligation’ of health surveillance (Howson 1998), negotiated in relation to different women’s personal lives (Armstrong 2007; Armstrong and Murphy 2008).

diagnostic measures/interventions and being ‘keepers’ of medical and/or speculative knowledges about biological inheritance (Markens *et al* 1997; Longhurst 1999; Abel and Browner 1998; Root and Browner 2001; Emslie *et al* 2003; Lupton 2011). Pregnant women are not only expected to obey their doctor’s expert advice but also to themselves seek out, and comply with, ‘reliable’ (biomedically-endorsed) information, such as from books, magazines and the Internet (Abel and Browner 1998; Lowe *et al* 2009). Discourses around maternal health and, crucially, infant survival/health ensure that such information carries significant responsabilisation weight and particular emotions (fear, shame, guilt, stigma) can be utilised with the intent to ensure compliance – although punitive approaches can backfire (Daniels 1999). As such, embedded in a wider context of Foucauldian discipline, online resources such as the NHS Direct website (Parr 2002) and discussion groups such as ‘babyworld.co.uk’ (Madge and O’Connor 2005) are now commonly used by many.

Subsequently, the ‘online terrain’ of pregnancy loss can be seen as an extension of longstanding (self)disciplining practices concerned with pregnancy, health and care for women, involving: bodily vigilance, health-information seeking, emotional encounters, pre-natal and post-natal care, longitudinal responsibilities for parenting, and recounting and remembering ‘family’. Yet, simultaneously, pregnancy losses also complicate and unsettle ‘preparation-for-parenting’ and ‘parenting-in-practice’ activities and expectations. Narratives of ‘family’ with linear expectations and hopes for a living, growing child are disrupted by events of pregnancy loss, often leaving little to no material artefacts evidencing that a child socially and/or biologically existed (Bleyen 2010; Layne 2000; see also Chapters 7 and 8). Subsequently, one’s identity as a parent/mother may be questioned by potentially oneself and others (Murphy 2012a, 2012b). The dominant rhetoric surrounding pregnancy of celebration and joy, alongside high expectations of medical heraldry and narratives of constantly-progressing scientific advancements, can have devastating consequences for pregnancies with ‘unhappy endings’ (Layne 2003b).

Particular ‘risk’ discourses compound the insistence on being a ‘responsible’ parent/mother at all stages of pregnancy and, in some instances, pre-pregnancy with punitive and condemning consequences if/when pregnancy

losses occur (Gallagher 1987; Warren 1989; Pollitt 1998; Daniels 1999; Hartouni 1999). Thus, if “[d]isease and death are no longer regarded as forces of nature but as unnatural affronts to our proper state of being” (Miller 2004 p41) and the maternal womb is deemed the ‘first environment’, responsibility-blame can be problematically and unfairly attributed to women who experience pregnancy losses (including by themselves). Pregnancy loss support groups can thus provide spaces to negotiate and challenge the wider context of individualising and perhaps excessive responsibility placed upon women for pregnancy outcomes that are often beyond their control and antithetical to their own wishes, and redefine themselves as valuable (not ‘failed’) mothers and/or women.

Since many participants had used websites aimed at providing information and discussing their pregnancies, it is logical that some also sought out web-based groups specifically about pregnancy loss or used particular discussion threads during/following these. Again, reiterating how Internet users do not merely leave their physical bodies ‘behind’, since their pivotal focus reinstates and mobilises around particular bodily experiences and processes, this realigning of online groups pertains to the changing bodily specifics at hand as ongoing pregnancy shifts to pregnancy loss. For example, Anne described using multiple discussion groups on the same pregnancy/parenting website in relation to the different events and stages of her second pregnancy which ended at full term in stillbirth. Anne’s transition from the ‘general’ pregnancy forums to the more specific ‘pregnancy and infant loss’ board highlights the ways in which online engagements with informational and discussion groups do not simply ‘cease’ when pregnancy loss occurs, but follow the embodied temporalities being experienced in the ‘offline’ world. For some women in the research, learning of pregnancy loss was immediate and certain, meaning that their identification with one discussion group generally on pregnancy could change abruptly to one on pregnancy loss. For others, the drawn-out diagnosis or ambiguous occurrence of pregnancy loss entailed significant periods of waiting and being ‘in limbo’, meaning that this embodied situations also translated into uncertainty about which online groups they should/could use.

As I have suggested, the ‘online terrain’ of pregnancy loss is comprised of multiple spaces, networks and activities, around sometimes contentious and

contested topics/viewpoints – making it a complex, interesting and important research site. This includes, for instance, work attending to the relationship between stillbirth photography and digital production, storage and image modification (Mander and Marshall 2003; Godel 2007; Pauwels 2008; Gersham 2009; Keane 2009; Davidsson Bremborg 2012). For Godel (2007), the vast diversity of content, structure and usage across stillbirth photography websites renders it difficult to comment on uniting/essential features. My use of the term ‘terrain’ is not intended to signify stability or coherence; rather, I recognise that, because pregnancy loss support is in many ways still inchoate given its marginalisation from the mainstream, online resources/activities exist on a largely ad-hoc basis with implications for how potential users ‘come across’ or miss pertinent spaces and resources.⁴⁵

Information-seeking Online

Across participants, the most frequently reported use of the Internet was to search for practical information, although this activity often merged and blurred with using discussion support groups for requesting and sharing information.⁴⁶ Commonly recalled information found online about pregnancy loss included details about the physical processes, miscarriage management options, campaigns (around awareness-raising and resource-allocation) and signposting to support services (whether these be discussion group, email, telephone or face-to-face based, as well as some further reading/leaflets and PDFs). Some participants appreciated the information found online whilst others deemed it inadequate, often linking—in both cases—with feeling underprepared and ill-informed by medical staff. The ways in which search engines operate, varying depending on the specific words entered, means that

⁴⁵ Some participants conveyed a sense of ‘chance’ in locating particular information or resources online about pregnancy loss, raising issues of online “spatial legibility” (Dodge and Kitchin 2001 p172; see also Lowe *et al* 2009). Isabel, for example, described how she “just stumbled across it [a pregnancy loss support/information website] and just out of curiosity I thought I’d have a look and a read through” which she then used, viewing but not posting, several times.

⁴⁶ This is despite requests on many of the sites that the discussion provisions are for emotional support rather than medical information. Moderators of the discussion boards were largely described by research participants as supplementing, rather than dominating or controlling, the groups, thus supporting the widely held self-help ethos but somewhat masking the moderating that does occur and the consensus-determined rules at play (Drentea and Moren-Cross 2005).

the ad-hoc results can be deficient. As Fiona summarised, “I wanted more, I wanted answers, information”. For Holly, the online information about pregnancy loss was largely deemed inadequate and inappropriate for her miscarriage circumstances and she commented on one pregnancy loss website in particular which she found very difficult to navigate. Her experience supports the need for further attendance to the spatial cognition of such websites in order to successfully support users in “navigating, searching and understanding of information spaces” (Dodge and Kitchin 2001 p172).

Lay uses of the Internet for health information entail a number of benefits as well as provoking some concerns. For instance, it can be seen as democratising and empowering patients with a renegotiation of roles, bypassing medical ‘gatekeepers’ and negating bias/strategies which might limit treatment options (Broom 2005). Yet, the potential for transforming the patient-doctor boundary is not embraced by all. Although half of the participants approaching/undergoing menopause in the research by Henwood *et al* (2003 p590, p601, p602) used the Internet in their “information landscapes”, some of women conveyed “great concern about appearing to overstep the boundary between ‘expert’ and ‘patient’” and that the ‘informed patient’ would be “exerting extra pressures on an already busy [health] professional”. This reluctance resonates with comments from prostate cancer medical specialists interviewed by Broom (2005 p331) whom articulated finding Internet-informed patients to be “annoying or irritating”. For many of my participants though, using online information was not deemed an actively chosen endeavour but rather an unfortunate result of ‘proper’ medical establishments being unwilling or unable to provide required/wanted information.⁴⁷ Anne, speaking about her first pregnancy loss which was an early miscarriage, turned to the Internet for information about the anticipated physical processes because she felt she had not received adequate information

⁴⁷ This motivation was also mentioned by Kivits (2004) who also noted that the information gleaned from independent searches is often strategically managed during subsequent consultations with one’s doctors. This can be an especially important negotiation for those who struggle to be seen by medical professionals as ‘credible patients’, such as for women who experience chronic pain and/or illness (Werner and Malterud 2003; Werner *et al* 2004; Crooks 2006). Subsequently the ‘informed patient’ can be understood as both a de- and re- investment in the authority of medical professionals (Kivits 2004).

from the hospital: “I was very worried about what I would see, would I see anything, you know, at that stage [...] I could of really done with a doctor talking to me about those kinds of things as well [as finding information online]”.

The specialists in Broom’s (2005) study expressed concerns about the potential of Internet use to overload patients with (inaccurate) information. This concern about the quality of online health information is especially acute given that, as conveyed by my own participants as well as those in other studies (Hardey 1999; Henwood *et al* 2003), information searching via the Internet tends to be ad-hoc and unsystematic. It is not only that unreliable (misleading, gaping) medical ‘information’ can be found online or, as Holly suggested, that this coveted knowledge may be absent/difficult to access but, given the sensitive context, that distressing sites and sources may be returned. In addition to the video encountered by Holly (Chapter 5), Fiona suggested that the returned search engine image results could contribute or compound distress more so than seeing the materiality of one’s own miscarriage:

I kept going back to [the Internet], because I'd go online looking for a specific thing and after I came away from it there'd be something else that I'd thought of [...] The only thing that really got me sometimes on these sites there'd be images popping up, for instance on google if you were to type in miscarriages and go to images they'd be pictures of actual miscarried babies. I thought that after everything I'd seen that it was horrendous. Before the miscarriage it would've been a terrible thing to see, after it these images were haunting.

Though not specifically mentioned as something encountered by participants when searching for (textual or visual) information about pregnancy loss online, I have concerns about additional distress which might arise from exposure to deliberately emotionally manipulative and propagandist images of fetuses on ‘pro-life’ websites or other media outlets. Such images, often knowingly gruesome, are intended to invoke horror, guilt, shame and grief in viewers (Stabile 1999) and can do so regardless of the form or context of pregnancy losses experienced.

Whilst I have suggested here and in Chapter 4 that it is predominantly women with physiological experience of pregnancy losses who seek/receive support, online information-searching was described as an activity that other family members sometimes also engaged in. For instance, Siobhan explained how she took on the role of information-seeking on behalf of her pregnant sister who had received a diagnosis of a rare, terminal, genetic disorder affecting one foetus of twins. Describing herself as more computer- and educationally-competent than her sister, Siobhan spoke about the online information and support-resource locating activities in a number of ways. This included being a form of care towards her sister, protecting her from information she deemed unnecessarily distressing, such as rare complications, and accompanying 'extreme' visual images. Siobhan looked online:

primarily for me to get a grasp and then if I knew I understood it then I could explain it or manipulate it in such a way to my sister, to pass on the information, but leaving out the things that she wouldn't HAVE to find out unnecessarily that might make her more stressed or worried.

Lowe *et al* (2009 p1481) suggest that the Internet can provide valuable access to information, especially for rare diagnoses, and permit multiple re-reads as well as specialised inquiries, subsequently helping some to feel "more in control of the situation". Thus, seeking information online was done by Siobhan to help inform her sister of the medical situation, with preparation for the almost-certain outcome of neonatal death and alleviating self-blame, as well as for Siobhan to inform herself in order to confidently occupy her anticipated role as birth partner. Following the birth and neonatal death of her nephew, Siobhan also attended meetings about the post-mortem autopsy results in which she found the use of medical jargon and the delivery of the information frustrating. This was despite her considerable Internet-based 'information literacy' (Henwood *et al* 2003) about the disorder:

Siobhan: they tried to break it down but it was still very medicalised which was quite difficult to understand and I went with her [my sister] for that reason, erm, because - well this might sound pretentious, but erm, my sister is not very literate and she has quite a difficulty with understanding big words, as she would

say, so I was there to try and help her understand and I found it quite difficult to understand some of it. And I actually went home with the findings and went through them by Googling some of it. Abi: even having done the research [online], it was still quite...? Siobhan: still quite difficult to understand, yeah [...] this doctor that presented the findings [...] seemed very nervous and she seemed to like fall over herself quite a lot which is understandable if it's your first time [presenting findings], but I think in terms of how it made my sister understand – it wasn't very helpful really or what was appropriate.

Whilst many participants used search engines to try and decipher the medical terminology they had encountered in, for example, hospital, this practice sometimes returned *additional* medical language. It was discovered at the 12 week scan that Jane's second pregnancy had stopped developing around the three/four week point. A message from a discussion group moderator, rather than the sonographer or doctors at her EPU, revealed and explained new medical terminology to her: "[the moderator] described my experience as an anembryonic miscarriage which is a term I hadn't heard of before". In addition, and linking to Chapter 5, a key domain of searching online for new or supplementary information concerned uterine blood loss, including the onset, duration, heaviness and regarding differential tissues in the flow. This sometimes also pertained to uncertainties about whether medical services ought to be contacted or visited. Lara, unintentionally pregnant and unfamiliar with the UK health system, considered both pregnancy and miscarriage to be unusual for "people our age" so that looking online was a first call endeavour rather than asking her peers. Another underpinning aspect can be limited opening hours and operating practices of local health/medical facilities (McLean and Flynn 2012; National Institute for Health and Care Excellence 2012). Fiona, unaware she had been pregnant prior to miscarrying, explained that:

[t]he doctors in my local surgery split their time between different towns so I knew that there would be no chance of being able to speak to my own G.P at the time. Even to visit A & E at our local hospital, you have to phone NHS 24 beforehand unless it's an absolute emergency.

Various kinds of decision-making processes drew on online information searches. For instance, Gemma, situated with the difficult “individualized decision-making around prenatal testing” (Ginsburg and Rapp 1999 p280), looked for information online following a positive diagnosis of spina bifida. McHaffie (2001, speaking about neonatal end-of-life care) and Hunt *et al* (2009, in the context of terminations following diagnosed foetal anomalies), foreground the importance of having access to comprehensive, multidimensional resources to support decision-making. However, Gemma “only found stories of people who had continued with the pregnancy and descriptions of their beautiful, brave amazing children today [...] there really wasn’t anything to support parents in making a decision online”. This resonates with comments by Ginsburg and Rapp (1999) that (multiple) knowledges about foetal diagnosis are segregated, foreclosing ‘socially informed consent’.

Recollections of related online activities tended to be fragmented in terms of how different piece of information were found online. These can retrospectively merge in order and timing; as Gemma commented: “my memories might be getting mixed up here from post-delivery and sort of pre-delivery and various Internet searches”. Many participants in the research could not remember specific details like the names of viewed websites or routes through searches and potentially conflated the information, content and layout of multiple sites in their interview narratives. It is likely that this relates to the ubiquitous manner in which many individuals use the Internet for information searches, potentially very frequently and cyclically as new queries develop. It could also relate to the emotional distress and shock of pregnancy losses rendering one’s memories/recollections “a blur”, a verbatim remark by Anne, Victoria, Fiona and Isabel. There was, however, a strong emotional recollection of feeling a ‘need’ to locate and accumulate information via the Internet. Through doing so, many of the participants learnt of and sometimes began engaging with online pregnancy loss support and discussion groups.

Online Support Groups and Consolation

Similar to information-seeking, engagement in online support and discussion groups also followed changing circumstances from pregnant to no longer pregnant/undergoing pregnancy loss. It was often within these virtual locales that both the statistical frequency and ‘human’, emotional realities of

pregnancy loss were encountered. This was sometimes contrasted to their ‘offline’ lives and the ‘real/geographical’ spaces they inhabited; Anne said:

I’m very lucky, I’ve got a lot of friends all or most of whom have been wonderful, but... it’s been really good to talk online, on this community, with women in the same situation because I don’t physically know, I don’t know anybody else in my *real* life {laughs} if you see what I mean, my ordinary kind of, normal life, who’ve had a stillbirth – I don’t *actually* *KNOW* of anybody.

In online support and discussion spaces, users can: read posts from others; write one’s own posts, for example about physiological situations; pose questions and provide responses like offering recognition of one another’s experiences; share inspirational or consoling quotes, sometimes one’s own poetry, and images including photographs, pregnancy loss related symbols such as rainbows, footprints or the blue-and-pink ribbon, and, controversially, ultrasound scan images within messages or as signature lines and profile thumbnails; and signpost to other information sources and/or websites.

Comprised of these activities, such sites can be highly valued as remarked Anne: “it’s a HUGELY supportive community and that’s been incredible for me”. Some information from this group appreciated by Anne was practical, like the cessation of onset lactation (Chapter 5), but she also praised opportunities for emotional support with efforts to legitimise and normalise particular feelings:

what you find is... we all say the same things, we all say really similar things when we first, you know, lose a baby, we have very similar thoughts and you just want someone to tell you it’s normal, you just need someone to say ‘this is okay, whatever you think at this time is okay’ because you think some really wacky things {laughs} you just need to be reassured it’s alright.

As Anne suggested, online support groups for pregnancy losses can therefore be “validating environment[s]” (Gold *et al* 2012 p70), with the articulation of and collective responses to emotional narratives a potentially very important dimension of sense-making regarding one’s lived experiences (Bar-Lev 2008).

The online groups were sometimes described as preferable to face-to-face support. For instance, very few women, let alone their partners (linking to Chapter 4), were offered professional counselling at the time of their pregnancy losses. For some who had later pursued this route via their GPs, there were potentially additional restrictions including around childcare. Victoria explained that her GP had given her a telephone number to arrange counselling but that “it looks as though it is [m]ore [for] women who have had abortions and anyway I would not have anyone to look after my [young] son”. Other issues included that many of the known face-to-face support groups met infrequently, meaning limited support, and at times which clashed with other commitments. Additionally, some groups met a considerable distance away from participants’ homes and/or in hospitals/EPUs, environments which could serve as traumatic reminders. In contrast, online groups were often seen as beneficial in terms of: asynchronous yet often rapid response communications; 24/7 availability for use at ‘unsociable’ hours and convenience, providing one has Internet access; anonymity and being comprised of strangers, at least initially, thus minimising a feeling of being ‘burdensome’ to known others; allowing the disguise, moderation or self-composure of emotional expression but, conversely, also being perceived as pseudo-private spaces for candid emotional expression.⁴⁸

Online ‘support’ was articulated by several participants as involving: recognition; empathy with/from those concurrently and sympathy from those who felt compassion without direct/current experiences; consolation; an opportunity to share; and a sense of belonging. The reciprocity of giving and receiving support was often foregrounded; for instance, Anne felt the online discussion groups provided her with “REALLY vital support, so I just want to be able to give that support to someone else”. Subsequently Anne had posted on the support groups about “things that have helped me cope [...] and as you know, it is very much a cycle of support, most women post on their when they need support and then also... are able to give a lot of support as well”. This

⁴⁸ This prospect of anonymity, as perceived to be a benefit of online groups in other studies also (for example: Malik and Coulson 2008), links to earlier discussions in Chapter 4 about talking to an otherwise unknown researcher. For instance, Anne commented that she is “in some ways more open [in the online support groups], because I’ve been able to post saying ohh, you know, ‘this is a particular issue’ or ‘I’ve been thinking this’, you know, ‘does anyone else think this’ whereas I wouldn’t necessarily go tell my mum I’ve been thinking that or whatever”.

included sharing her experience of finding it beneficial to view her son's coffin prior to the funeral (see also Chapter 8) and she later moved to also being a moderator. Similar observations about 'passing on' support have been made about face-to-face pregnancy loss groups whereby members feel a need to 'pay back' (Layne 2003a). However, some participants such as Isabel valued the choices of engagement available in online groups, meaning that "it's up to you when you actually do the posts or have a look at what people are saying".

Different degrees of participation, including lurking but not posting so that one need not even be identified as 'present' in the group, can be facilitated by the groups being online. Isabel explained:

I think it is good to do it [talk/think about pregnancy loss] online because you're not face-to-face and so erm... I don't know, even though it's nice to have somebody with you to sort of give you a hug maybe or comfort or hold your hand or something like that but at least if it is online it is slightly more private... in that somebody can't actually see how you look, like if you're sat there crying your eyes out or something and you're more in control of what you tell people as well.

Face-to-face support groups, in contrast, entail visible bodily presence and physical proximity to one another whilst cyberspace discussions *about* embodied experiences and processes do not require one's actual material body to be present. Describing the time between suspected missed miscarriage and the onset of bleeding, Esther described feeling "like the world had stopped [...] I didn't want to go out, I didn't want to do anything, I didn't want to see anybody". Several days after the news of suspected miscarriage via blood tests, Esther's mother visited and attempted to re-establish a routine by "doing things like... the shopping and making us eat and making me leave the house and making me have a shower and brush my hair and MAKING us have some normality about life". Whilst this encouragement can be helpful, it could also be comforting that in an online support group one need not worry about their bodily presentation: staying in pyjamas and/or unwashed, both of which some participants described as related to their shock and distress; emotional displays of crying; or interruptions such as having a break, logging off and/or taking some time to articulate one's thoughts before voicing/typing them.

Those who experience pregnancy losses are positioned between the painful realisation of the statistical frequency and the enduring public perception that these events are abnormal. Through the coalescing of persons using the groups precisely because they have experience of pregnancy loss, the online spaces challenge their otherwise conferred 'abnormal' identities and bodies. In these groups, pregnancy loss experiences *are* 'normal' in the sense of being a presumed prerequisite for use. The online groups translate (some of) the statistical frequencies of pregnancy losses into a visual-textual 'presence', as cyberspace sites populated by those with similar experiences to varying degrees. The groups can thus be seen to materialise a response to the question phrased by Letherby (1999 p178) as "[c]an an event [like miscarriage] that is statistically so common be 'abnormal'?" and reaffirm Ivry's (2010 p6) comment that "pregnancy is a much more common experience for women than birth". The sociality enabled by online pregnancy loss collectives can therefore be experienced as one of support, recognition and consolation, contrasting to other spaces in which inter-personal relations have been uncaring, potentially well-intentioned but nonetheless insensitive and/or ignorant. Subsequently, Holly noted, the online groups can feel "like a little club {laughs} [in which] you can see the support that the women give each other". Caroline, who experienced her four miscarriages prior to Internet access/proliferation, had relied on telephone support. Whilst praising the support she had received then, Caroline commented that she thinks "it's good that these women come together [online] and support each other" now that "the Internet has taken off".

For some participants, their engagement in the online support groups also benefited their wider, 'offline' lives. Lisa explained that, for her, "the [online] support was overwhelming [in a positive way] and it encouraged me to be able to talk to friends and family about what had happened". However, the merging of the offline and online is not always without hitches. For instance, some of Jane's Facebook friends, whom she had informed of her miscarriage via private message, wrote on her profile wall prior to her being able (or choosing) to disclose her experiences to her family-in-law. She explained: "I don't think anyone actually stated [on my Facebook wall] what had happened, but it was easy to work out when most people knew I was going for my scan that week". This ended up being, at least in one sense, beneficial as it meant that Jane "didn't actually have to 'tell' them" herself, which was something that she had

been finding especially difficult. Likewise, Esther had found it helpful to use Facebook to communicate about her experiences of pregnancy loss: “I actually then made the conscious choice to communicate to friends and wider family what had happened using that [Facebook] message”. For Esther this “was a way of telling my friends where I was, what was wrong, because a lot of them knew something was wrong and it was a way for me to say ‘this is what is wrong’ and unconsciously ask for their support”. When I asked Esther about received responses, she elaborated:

oh, you know, it’s things like that that actually tell you who your friends are, your real friends, your true friends, people who really REALLY care about you and the response I had to that was phenomenal, it really was. People who care about us, people who sent messages of love, it really was – it was a response that really touched both of us [me and my husband].

However, as will be discussed in the following sections, it is not the case that the online pregnancy loss groups are exempt from producing or entailing negative experiences in various ways for some individuals.

‘Support’ Challenged

Several aspects emerged in the interview narratives of my research which elaborate on ‘negative’ aspects regarding online support groups, beyond the potential distress from reading collective experiences and/or misunderstandings with taking posts ‘the wrong’ way (Malik and Coulson 2008). In this section I will outline four somewhat interconnected aspects. The first will concern the ways that online support groups can highlight the lack of recognition and appropriate support within one’s wider, offline life and yet also retain this unevenness as ‘enclaves’. The next aspect pertains to well-entrenched critiques of the concept ‘community’ in which boundaries of belonging are delineated in opposition to those ‘excluded’ and deemed ‘outside’. For those pregnancy losses entailed particularly stigmatised components, such as termination for Gemma, or deviated from the predominance of users being women who have physiologically experienced pregnancy loss, as for Siobhan, the groups were anticipated as not ‘for’ them and that they could be ‘unsupportive’. This lends to a consideration of hierarchies and I will discuss

some of the ways in which stigma can be displaced onto others. As this section will address, the language of ‘support’ can mask the ways differences between pregnancy losses can fracture or exclude some persons from the groups.

Enclaves

It is apparent that some women, in my research and beyond (see Gold *et al* 2012), find the online groups incredibly valuable and were able to utilise confidence and communication skills developed here to benefit wider (offline) lives, but this was not the case for all participants. Whilst there are attempts to further disperse awareness about and support resources for pregnancy loss, such as The Miscarriage Association moving beyond their online presence with the blue envelope campaign launched in February 2013, it is unclear as to how successful these are in countering longstanding and widespread denigration.⁴⁹ The online groups potentially constitute enclaves in which appreciated forms of ‘support’ and recognition are contained rather than distributed more widely. Demonstrating interplay between offline and online space (Madge and O’Connor 2005), participants and my own informal observations suggested that comments in the online pregnancy loss groups frequently consist of ‘venting’ about experiences in the offline world. This includes insensitive comments from family members, withdrawn partners and dismissive treatment by medical staff but also responses of silence on a societal scale. As Penny explained in the context of miscarriage: “no one else talks about it[,] only other women who have been through it”. Thus, whilst the support online in the groups can be valuable, this is often contrasted to ‘offline’ lives, with the discrepancies forming a core feature of the online group dialogues.

A number of participants were acutely concerned that their involvement in the online groups might be visible to known others. This included, for instance, that the groups are visible to or can be accessed by anyone with an Internet connection and, for support groups/pages on Facebook, were linked to their profile. There was awareness that online posts, often about experiences which occurred offline and pertain to wider embodied lives and encounters in

⁴⁹ The blue envelope campaign entailed the simultaneous display of posters at prominent railway stations and the wider dispersal in ‘everyday’ spaces of blue envelopes foregrounding the statistical prevalence of miscarriage to encourage more open discussion about these events as well as signposting to the MA helpline (The Miscarriage Association 2013b).

‘real’ space, might be seen by known others and have implications offline. For instance, Victoria was a member of several groups on Facebook: “but I very rarely join in the discussions as I do not want my [Facebook] friends to be able to see what I write”.⁵⁰ This is understandable in terms of protecting one’s privacy, but it also highlights a tension in which there is salient reluctance for such information/discussion to ‘leak out’ of established support group contexts. As Esther summarised, “some people don’t like incredibly personal things on Facebook” and thus pregnancy loss experiences may be tightly guarded rather than aired. A few participants suggested that they were more forthcoming in offline contexts, having more control over who ‘knows’; Beth explained that she does not “really hide the fact I had a miscarriage. I don’t shout it down the street or post about it on Facebook, but if I am in a [face-to-face] conversation with someone about our pregnancies then I don’t mind talking about it”.

Subsequently, for some, it seems that the online support groups are potentially an unwanted source of information about their lives—that they had a pregnancy loss and/or more detailed information about this—which they wished to be kept apart from their social relations with others who are also or potentially known offline. The ways in which the online groups can in effect produce a form of sequestration of pregnancy loss experiences is therefore something that users unintentionally reaffirm through their reluctance and fears about such information and conversations breaching the boundaries of the specific online groups and entering the knowledge of others. This is in contrast to aspirations about pregnancy loss recognition being dispersed into wider social settings, as the notions of awareness-raising and the comments made frequently about the desirability of breaking the ‘silence’ suggests, with the goal of altering the perceived mainstream overlooking of these experiences. Frost *et al* (2007) have discussed the ways miscarriage is sequestered as a private

⁵⁰ Even if a person does not actually post in such Facebook groups, their ‘membership’ may still be visible to others and thus inferred that they have personal experience of pregnancy loss. Some pregnancy loss support groups on Facebook also have ‘private’ groups so that activities in these groups would not show up in the feed of the users’ ‘friends’. Knowing this, I signposted Victoria to the existence of a private group, similar to those she described about miscarriage and ectopic pregnancy losses, which she joined but was not using “at the moment as I am very emotional and every time I read someone’s story it makes me cry!” The fact that the narrated experiences of other users on the online groups could be overwhelmingly distressing was an observation also made by Malik and Coulson (2008) in their research on infertility.

matter; whilst undoubtedly an improvement on this, widening the scope of recognition, I am suggesting that the online groups can themselves be constantly renewed enclaves struggling to expand awareness further.

The online support groups can also expose users to a seeming collective consensus that diverges or jars with their own experience and time-limited opportunities or financial capabilities. Whilst particular values and responses towards pregnancy losses can be supported which might otherwise be demonised or misunderstood by outside/offline others, these do not always sit comfortably with everyone. This is especially the case if the time frame in which the seeming predominant or ‘best practice’ memory-making and memorial approaches of others could be implemented in one’s own situation has passed; for instance, Isabel joined an online support group after her late miscarriage:

when I started reading stuff like that [about what others had done after their pregnancy losses], then that’s when I started getting ideas in my head and thinking oh no I should of dealt with it differently, I should of given him a cuddle and should of seen him.

Isabel did not visit any online support groups until after the birth of her deceased child at 20 weeks gestation because “[a doctor] said to us as well ‘don’t start looking on the Internet, don’t start googling all of this because you’ll read loads of horror stories and you’ll read lots of things and it’s just not a good [idea]’”. As it turned out, the doctor himself presented a disturbing image to Isabel, resonating somewhat with the ‘meat’ comments made to Anne (Chapter 3). Whilst it is important to provide some preparation to the sensorial specifics of encountering deceased babies (Rådestad *et al* 2009), some comments can exacerbate upset, dread and fear. The doctor who advised Isabel not to see or cuddle her baby “said that at that stage, that the foetus would be, I don’t know whether he described it as a foetus, but, you know, the baby would be – he described it as it would look like an alien sort of thing”. Isabel implied that, if she had visited the groups and if the doctor had been more careful with his wording, she may have reconsidered the decision about contact:

I was just sort of erm going by the advice that I was given and then I was just, I suppose I was thinking I’d deal with it in that way, as if it wasn’t happening type thing so I didn’t want to see him, I

didn't want to cuddle him or anything... but in hindsight I wished I had like given him a cuddle because, you know, that was my little baby and... you know, it's sad really.

Exclusions

There are a number of ways that the online pregnancy loss support groups, as with other cyberspace communities, "are not all-inclusive and are subject to geometries of power" (Dodge and Kitchin 2001 p55). In processes of (re)constructing individual and group identities within the online support communities, there remain exclusions and exceptions such as those who feel that they are not/would not be welcome. As I discussed in relation to Siobhan in Chapter 4, the groups can be widely perceived as 'belonging' to women who physiologically experience pregnancy loss, linking to feelings that the grief of social others (like siblings) is not legitimate and should not be seen or heard (Peskin 2000). In addition, feeling 'unwelcome' in the online groups, and potentially other forms of support such as face-to-face meetings, can stem from the ways in which particular forms of pregnancy losses are stigmatised or deemed 'less' significant than others. Earlier in the chapter, I demonstrated that the online groups can constitute exceptional spaces in which the frequency and impact of pregnancy losses are revealed: (virtual) locations populated by those with these experiences as opposed to the rest of one's (offline) life in which one may not know anyone else who has, as for Anne, experienced stillbirth. Notions of normality specific to the group context are produced through the collation of persons in the online spaces, permitting particular assumptions to crystallise about the 'we' inhabiting and the 'what' of their experiences. I argue that the particular kinds of pregnancy loss experiences represented or anticipated to constitute those predominantly experienced by group users can have the effect of rendering other experiences 'outside' or, especially if they unsettle some of the core assumptions and discourses being utilised, 'unwelcome'.

The online groups enable 'normalisation' in that everyone 'there' is assumed to have experiences of pregnancy loss, yet the variety and circumstances of pregnancy losses are not necessarily the same. For instance, pregnancy losses pertaining to terminations for foetal anomalies are often in a particularly difficult position: narratives of choice and autonomy are deeply inadequate but it cannot be said that agency is entirely removed either. It was

clear that Gemma's decision to terminate a 21 week pregnancy after an ultrasonography diagnosis of foetal spina bifida was deeply ambivalent, commenting on one occasion that "it was almost like I knew the decision was [already] made in a way" and on another that:

I can't even think back to the decision making process, I don't know how we decided what we decided, I know that it was rushed, I couldn't cope with the situation and wanted it 'treated' or resolved as quickly as possible, I wish now I had given my baby more time.

Certainly, this had implications for the ways Gemma felt about the prospect of engaging with online or face-to-face support groups. In addition to limited online support resources relevant to her circumstances, she also conveyed a sense of feeling that she was not eligible to seek socio-emotional support and that her legitimacy to do so might indeed be contested by others:

I didn't find much support or discussion around pregnancy termination [online], [there was] support for those who continue with a pregnancy like this, and for those who have lost babies naturally, but I didn't feel entitled to use these networks as there was a lot of guilt involved in what happened to us.

This echoes with Layne's (1999) comments that discussion of termination is often side-lined within miscarriage support group newsletters, and I suggest this is also the case in many online support groups. Although Gemma had not felt able to seek and/or receive support online or in a face-to-face group, she explained that she would like to provide support to others but that "I am not sure how to do it":

Gemma: [after seeing a message about online miscarriage support group, I first] thought oh I would really like to give support to other people who are in the same situation as I was in but it's less easy to kind of [do]. I don't think people would just advertise that... do you know what I mean?

Abi: advertise your situation?

Gemma: yeah, like erm, you know, 'have you ever terminated a pregnancy? Do you want to offer support to other people who

might be in that situation?’ {laughs} erm, so I guess there’s a sense that there might be some stigma or some kind of emotions attached to making that decision from other people and so you don’t always want to bandy it around casually.

Gemma had not received actual responses of rejection or exclusion from the support groups, not having used/posted in them, but the fact that she anticipated such responses is significant. As I will now discuss, the fact that the online groups were not experienced as welcoming or suitable for all pertains to additional ways in which pregnancy losses are differentiated which, whether intentionally or not, can enable forms of problematic comparison.

Hierarchies

One predominant social and academic assumption regarding pregnancy loss has been to consider later gestation losses ‘more significant’ with stronger and longer levels of grief, depression and anxiety than earlier losses (Toedter *et al* 1988; Goldbach *et al* 1991; also: Brier 2008 gives a comprehensive summary). Hence, building upon the pioneering work of Peppers and Knapp (1980), some scholarship has focused in recent years on miscarriages in an attempt to unsettle this presumption and demonstrate that a shorter gestational duration does not necessarily mean that the experience is felt as a less profound loss (Layne 1996, 1999, 2000, 2003a, 2003b, 2004; Letherby 1999; Davidson 2007). Caroline recalled talking with her friend who “had a stillborn child”, though technically this was neonatal death as the child died several days after birth, around the same time as Caroline experienced her first miscarriage of four. Evident within this recounted dialogue was a challenge to the normative assumption that miscarriages are less significant than later pregnancy losses. Caroline explained:

[my friend and I] talked a lot and she said to me, she said ‘[Caroline], I would rather of gone through my whole pregnancy, the birth and the death of my daughter than ever to have gone through what you’ve gone through because I ENJOYED my pregnancy, I got to know my daughter, I birthed her, I loved her and I buried her’ and she said ‘you’ve never had any of that and yet still that child exists for you’, she said ‘for you that child was still

alive' and, you know, that's coming from her. I was quite shocked because I always think it's worse if you go full term and THEN lose a child, I do, I think it must be horrendous but she didn't think of it in that way.

Caroline also elaborated on the ways her friend received tremendous support from the hospital and her wider social network after the neonatal death of her baby which contrasted to the lack of support Caroline had herself received:

[my friend] said that never at any point did she feel lonely, she said she had amazing support, they [medical staff] talked to her through EVERY minute, you know, every minute of the day, through what was happening, because it was clear she [the baby] was going to die as soon as she was born – you know, there was no chance she would survive, you know, but she [my friend] felt supported, she felt she had a *healing* process to go through after, somewhere to go visit, people would talk to her because *she'd lost a BABY*, you know, this was *a person, with a NAME* and a birthdate and all sorts and she said she thought miscarriage must be just so lonely.

Whilst these conversations constituted a form of valuable support and extended recognition between Caroline and her friend, I am also conscious of the need for a word of caution regarding approaches of comparing experiences. In 'elevating' recognition of the emotional significance of pregnancy loss experiences which are typically left on a 'lower rung', such as miscarriages, a hierarchical approach remains intact even as the 'levels' within them are shifted internally. In the context of the conversation Caroline described, this was negotiated between the two women. However, I am aware of the potential for this narrative to be deployed elsewhere, including on online groups which—as Malik and Coulson's (2008) respondents recognised—are exposed to additional risks of being taken the 'wrong way'/out of the specific context and received as a diminishing or undermining of other's pregnancy losses. The potential to posit distinctions about the *most* 'lonely' or otherwise distressing pregnancy losses, therefore, risks perpetuating an albeit revised hierarchy with a top to bottom pecking order. No participants overtly conveyed feeling that their pregnancy losses had been deemed less 'worthy' than that of others within the online

groups, although comments were made about feeling disappointed and somewhat isolated from other users if one was unable to find others in similar contexts of medical conditions. However, as for Gemma, concerns about different values like stigma being attached to particular forms of pregnancy loss meant that some participants had chosen not to engage with the groups at all.

In addition to details such as medical classification, other factors can be utilised in the (re)constitution of hierarchies and boundaries between normal-‘deserving of sympathy’ versus abnormal-‘undeserving of sympathy’ pregnancy losses. This potentially includes: number of losses; whether the woman has any pre-existing living children; use of artificial/assisted reproductive technologies (ARTs); conditions affecting infertility; sexual orientation; marital status; economic circumstances, as linked to private IVF treatment; age, with teenage pregnancies deemed ‘mistakes’ whilst women over 35 years being deemed to have ‘missed their chance’, both prone to stigma; and history or consideration of terminations. This is not to imply that different circumstances are insignificant, since clearly they can have very practical and emotional implications. For instance, Peel and Cain (2012) highlight that lesbian couples using ARTs like sperm donor insemination who then experience miscarriages are faced with additional difficulties conceiving again. For several of my participants, various diagnosed conditions could also complicate and reduce the chances of subsequent pregnancies, as for Rosie in relation to PCOS. Subsequent to three years of trying to conceive with the intervention of ovulation-regulation medicine and an ectopic pregnancy requiring the removal of one of her fallopian tubes, Rosie and her husband were considering adoption. Clearly, the circumstances of pregnancy loss are not all the same, with crucial implications.

However, my point is that various factors can be brought into conversations in particular ways which, whether intentionally or not, can diminish some pregnancy losses as less significant whilst elevating others. Having living children does not ‘un-do’ or negate the fact of pregnancy losses previously or subsequently and yet this is a common attitude/comment encountered (Layne 2003a). Indeed, participants sometimes reinstated this notion themselves in the sense of feeling resentful regarding others reproductive and familial lives, relating to the remarks made by Holly about the assumption that others around you have/had relatively ‘easy’ pregnancies. Many

participants found it incredibly distressing to see other pregnant women, young babies and children especially those who would be about the age of their own if these pregnancies had not ended in loss. After her miscarriage, Holly felt like “there was just pregnant women everywhere and I was like ‘for God’s sake!’ {laughs}” This upset included a notably visceral dimension for Caroline:

I could NOT bear pregnant women – I used to feel physically ill when I saw pregnant women, physically ill, I wanted to go and throw up, and new-born babies was almost like you’d put yourself on the crucifix, no exaggeration, and you were being hammered - it was just SO [emotionally] painful.

Some participants spoke of circumstances that highlighted the ‘unfairness’ of their situation; as Jane explained: “I had feelings that it wasn't quite fair that I had lost my baby who would have been given so much love and care when there were other women having baby after baby and not being able to look after them”. Whilst not wishing to denigrate the upset of women who experience pregnancy losses in response to such scenarios, I believe there are some important tensions highlighted.

Displaced Stigma

Pregnancy losses are vulnerable to stigmatisation, given that such events flout linear expectations of ‘joyful’ pregnancy culminating in live birth and challenge the onus placed on pregnant women to be all-powerful determiners of their pregnancy outcomes. Many of the women spoken to were conscious that others might assume they had done something ‘wrong’ to cause the pregnancy losses. Isabel described how, in response to her sitting with crossed legs, a family member made a comment to her whilst she was pregnant following a late miscarriage: “she said something like erm... oh ‘if you cross your legs you’ll kill your baby’ [...] I was just absolutely shocked, I couldn’t believe she said that”. Feelings of responsibility were sometimes internalised to a point of questioning even seemingly untenable, minute actions as ‘risky’. Murphy (2012b) suggests, in the context of stillbirth, that some women reject stigmatised identities by seeking to ‘change the world for the better’ such as via: medical litigations to prevent similar mistakes happening to others, if this was found to be a factor; participating in the training of health professionals in terms of bereavement

care and education; and actively discussing stillbirth within their social circles in order to raise awareness. Some of these aspects emerged as significant also for my participants. Anne, for example, recounted a number of ways she was engaged in improving the socially, economically and psychologically inadequate environment encountered, including as a moderator on an online group and lobbying for funding further/continued preventative research on stillbirth.

Another strategy to reclaim moral identities, as for some of Murphy's (2009, 2011) participants, is to discursively differentiating oneself from activities such as smoking, taking drugs and drinking alcohol whilst pregnant: hallmarks of sanctions imposed around pregnancy. However, the ways in which stigma pervades pregnancy losses means that there is scope to shift 'discreditable' identities onto others deemed 'worse off', as in Bush *et al's* (2001) study on industrial air pollution. That is, to 'shake' one's own stigmatised/stigmatisable identity by accentuating another as *more* stigmatisable. Of course, this is not the only response to situations subject to stigma and I do not suggest that this is necessarily a deliberately malicious strategy. It is, though, an unfortunate implication that *can* occur when comparison is facilitated by demarcated boundaries and hierarchical levels entailed in efforts to 'prove' the significance of particular experiences. In displacing stigma onto 'worse off' others, dimensions of one's life can be highlighted as something to be pleased about or grateful for (Bush *et al* 2001). However, it can also have deeply problematic implications for the 'worse off' others if affirming oneself as morally-appropriate and non-culpable conversely engages stigmatisation and critique of pregnant women who do/did engage in activities deemed risky. Consequently, boundary lines between blame-worthy and innocent can be kept intact by those who safely identify as having 'followed the rules', and thus are deemed blame-free, in contrast to 'irresponsible' others. Subsequently, for women, including in this research, who had engaged in activities that are stigmatised, regardless of whether these were medically linked to causes of pregnancy loss, this was particularly difficult to navigate.

As I have suggested, there are multiple points around which distinctions could be made with regard to pregnancy losses, but of particular concern to me are those which attempt to differentiate between persons deemed innocent victims versus those who 'chose' the experience (via termination or in relation to

alcohol, smoking and/or illegal drugs during their pregnancies). In seeking to make such a distinction, the complexity and difficulty of different life experiences are negated. As I have argued, the language of ‘choice’ is severely lacking in relation to experiences such as Gemma’s termination following the detection of foetal anomalies.⁵¹ The realisation that some others might stigmatise her experience in this way underpinned Gemma’s decision not to partake in receiving or giving support in the online or face-to-face groups. Thus some participants knew about the forums but deliberately avoided them as they felt these spaces would be less welcoming to their involvement, less receptive to hearing about their pregnancy loss experiences and potentially hostile. Subsequently, it is important to recognise that, although the groups can provide fantastic, vital support for some people, there are also some who do not feel that they ‘should’ or ‘could’ partake. It is important to recognise that online groups “act as moral agents” (Bar-Lev 2009) and can include rather aggressive, consensus-based policing of belonging around particular norms and values (Drentea and Moren-Cross 2005). I am aware that this may well be the case for others regarding pregnancy loss groups beyond my research participants.

As also mentioned in Chapter 5, some participants described being irritated by other users whom they perceived as being ‘overly’ emotive and/or positing unhelpful advice. Helen felt “irritation/frustration” towards someone online who “basically ranted and gave everybody [...] a full update of what was happening and her outrage at the way she had been treated by the hospital”. Helen’s annoyance pertained partly to feeling that the other group user had a “lack of understanding surrounding what scans can and can’t do” (see also Chapter 3). Ambivalently, Helen simultaneously highlighted legitimate reasons to be distressed, regarding medical staff demeanour, whilst admitting that her reactions to other people’s written stories online are not always sympathetic:

I have found myself feeling frustrated with people when they are talking about the same experiences I had of early miscarriage –

⁵¹ Saxton (1998 p384 italics in original) argues for recognition of a key “distinction between a pregnant woman who chooses to terminate the pregnancy because she *doesn’t want to be pregnant* as opposed to a pregnant woman who *wanted to be pregnant* but rejects a particular fetus, a particular potential child [...] Prenatal screening results can turn a ‘wanted baby’ into an ‘unwanted fetus’”.

they seem so wound up about it – just as I was [then]. For me [now], it's just the way it is – though the way we are treated by medical staff at that stage really needs some attention.

Reflexively, Helen said: “perhaps it's actually regret that I spent a lot of energy feeling really frustrated and consumed with it [early miscarriage] – and wished I could have been a bit more 'take it as it comes' or 'what will be will be'...”

Carla had browsed some support groups in relation to two miscarriages but found that the content diverged significantly from her expectations:

Carla: like you know when you get bored and search on Ebay and you don't know what you're looking for until you see it and then you just buy it, it's that kind of thing only I wanted them [the groups] to tell me what to do but nothing jumped out and there were NUTTERS on them, like they [some users] didn't seem like, some of the stuff people were writing didn't seem real, it was like someone writing bullshit

Abi: what kind of stuff was that about?

Carla: it was like, there was like little 14 year olds like ‘I think I had a period, I think I was pregnant, I am so upset’ and it was like ...you've no idea about the real world, why are you on here?!

The ways other users spoke about their pregnancy losses jarred with Carla's own approach: “I'm very kind of matter of fact about everything as like over and done with, don't think about it anymore”. Carla felt that the online groups were populated by “people who had no idea about the real world” and the kinds of online discussions that took place adopted an approach that she herself considered irrational or senseless: “there were some people like ‘*arr I've been off work for three months*’ and it is like WHY? It's not going to reverse anything, get back to work, get your arse in gear and plus if you get back to work you kinda forget about it a bit quicker”. The groups had, for Carla, an ill-fitting dogma which posited advice that she felt would actually exacerbate the emotional and mental issues entailed. Though suggesting she was initially open to the idea of using/posting on the groups, Carla ultimately did not – as she felt “I can't be bothered with this so I just left it. I think if there had been one [group] that was just kind of like... even half sane people I would of wrote

something on it, but there wasn't anyone sane on there". Aspects of 'netiquette' (Dodge and Kitchin 2001) in the groups, such as sharing sympathies and encouraging further reflection/dwelling on experiences of pregnancy losses, were discordant with the indeterminate but presumably more pragmatic and/or stoic support that Carla had hoped she might find.

A plurality of pregnancy loss experiences—varying in terms of medical events, social circumstances, emotional reflections, and so on—render the sentiment that the forums provide access to other like-minded individuals with essentially the same experiences somewhat tenuous. In processes of (re)constructing individual and group identities, there inevitably remain exclusions and exceptions which fracture down numerous lines, including that of stigma and the 'undeserving'. Thus, the positive rhetoric of 'support' and 'community' can mask some very disagreeable tensions and exclusions, an issue which seems—as based on participant comments and my own albeit limited observations—largely visibly/vocally absent from discussion within the groups.⁵² There is resonance, I find, with Charmaz's (2008 p11) comments that:

[t]he core is enacted and made real in people's lives—by both those who enforce barriers and boundaries and those who experience them. People interpret the core, represent it to others, and act on their interpretations. Silence protects and perpetuates an established core.

Malik and Coulson (2008) acknowledge that their research respondents may have participated in their questionnaire precisely because they felt a sense of belonging and advocacy for the groups. In my research, recruitment was predominantly through online groups, but extended also to social network site snowballing with the re-posting of my CFP in other cyberspace sites/contexts. This, and with the use of qualitative interviews, meant that I was able to speak to some individuals detached from and/or unaware of the Internet-based pregnancy loss support groups. This has permitted consideration of some of the

⁵² As mentioned in the Methodology, I developed a degree of familiarity with the online support groups in order to appropriately navigate and negotiate activities such as disseminating my CFP on suitable threads. However, it was not my intention to produce ethnographic accounts of the support groups or to analyse the content of posts/comments from the groups as have Seale *et al* (2010) in their research on sexual health, breast- and prostate- cancer.

more problematic dimensions of the online groups, allowing for an exploration of factors which contest the assumption that the online groups are of benefit in all cases and further foregrounding the need to nuance notions of ‘support’.

Concluding Remarks

Online support groups are a significant component of the online ‘terrain’ of pregnancy losses, demonstrating cyber-space as an interplay between offline and online spaces/lives (Madge and O’Connor 2005) with physical bodies being simultaneously “reasserted and reconfigured” (Parr 2002 p86). Although many of my participants stressed very positive, valuable assets gleaned from using the support groups and/or seeking information online, there were also some accounts which highlighted reasons to be more cautious and critical. I have outlined several ‘negative’ aspects with implications for the online support groups not because my participants overwhelmingly critiqued the groups, but because these seem to be relatively undertheorised in pertinent academic literatures. Certainly the ‘positive’ dimensions identified by Malik and Coulson (2008) in their research on online infertility groups were also expressed by many of my participants. However, beyond the few ‘negatives’ Malik and Coulson (2008) identify, I have elaborated on several other components regarding marginalisation, stigma and exclusion. Similar to nuancing ‘the Internet’ in shifting representations of this from being an empowering, liberating technology to recognition of the multiple, complex and potentially contradictory implications, I suggest that such insights must also be acknowledged in relation to Internet sub-tenets such as online support communities. Boundaries which have long permeated ‘real/geographical’ spaces, distinguishing between inside-outside, do not merely dissolve online. Just as the Internet “simultaneously reconstitutes and reinforces the physical body” (Parr 2002 p75), so too there are other socio-emotionally saturated boundaries in ‘cyber-space’ (Madge and O’Connor 2005).

Potential problematic dimensions of the online groups include enclaves (the sequestration of support resources), exclusions (crystallising particular inside-outside boundaries), hierarchies (risking the legitimisation of some experiences at the cost of undermining others) and displaced stigma (affirming oneself by discrediting others). Through my discussions of these, it is reiterated that the online terrain of pregnancy loss is visited, utilised and ‘inhabited’ by

many persons with different perspectives, contexts and engagements. The online support groups, then, are a prime example of ‘cyber-space’ (Madge and O’Connor 2005); the fact that Gemma anticipated being unwelcome in the online *and* face-to-face pregnancy loss support groups demonstrates an overlap in offline and online spaces regarding the operating hierarchies which quantify and order particular circumstances for which, she feared, her experiences might be deemed undeserving and/or outside. Despite the contemporary nature of online technologies and usages, historical factors are not erased: some longstanding ways of thinking about earlier pregnancy losses as less significant are being challenged but not necessarily in a manner which overhauls hierarchical thinking, hence there are tenets of contingency too.

‘Support’ is powerful yet tricky and what constitutes a ‘supportive’ gesture or comment varies across situations. Those who experience pregnancy losses often encounter societal responses of trivialisation, exemplified by comments such as ‘better luck next time’ and that ‘it was for the best’ (Letherby 1999; Rowlands and Lee 2010). Such comments can certainly communicate dismissiveness, implying that pregnancies are inter-changeable as well as negating additional practical (fertility/conceiving) difficulties. However, it should also be noted that, for some participants, ‘well-intended’ comments are preferable to complete silence and/or pretences of ignorance. Additionally, ‘disapproving’ responses can come from those with personal experience of pregnancy loss, such as with the frustrations felt by Helen and Carla. Consolation is clearly not a ‘one-size-fits-all’ endeavour and providing support is precarious, as also discussed in the Methodology. Having personal experience of pregnancy loss does not guarantee abilities to decipher the ‘right’ response; as Isabel explained one reason why she views but does not post in the online groups is that:

I just wouldn’t know what to say to somebody who was saying ‘oh I’m feeling really bad, I’ve just lost a baby’ and stuff and even though I’ve been through it [miscarriages: one at 10 weeks, one at 20 weeks] myself and I’m seeing all these other people writing things online, I just wouldn’t know what to put {laughs} so I don’t, I just read it.

There is not necessarily a straightforward division between those who have experienced pregnancy loss and thus are ‘in the know’ versus those who haven’t, although this is a sentiment largely at the basis of the support group ethos.⁵³ In this chapter, I have suggested that this can lead to some troubling silences in, and exclusions from, online groups and, linking to the Methodology, I consider my approach towards self-disclosure as seeking to suspend or otherwise trouble the ‘split’ between these divisions. This is not to claim that autobiographical elements are absent from the thesis though since, as Volvey (2012 p125) comments, “the sensuous and emotional experiences attached to the practice of fieldwork-as-witness entails an increasing questioning of researcher self-identity”. Particularly pertinent to this is my interest in ‘the body’, a simultaneously academic and personal-emotional node of constant and sometimes disquieting fascination. As such, this chapter has offered a response to the comment that “if we look in other places on the Internet we can see that there are still other bodily stories to be told” (Parr 2002 p86). In the subsequent chapter, I shift away from the topic of coalescing, reconstituted bodies in the online context to think about the stories entailing the ‘individuated’ and yet relational skin, as the fabric and contoured surfaces of bodies.

⁵³ In some situations/for some individuals, the distinction between insensitive outsiders and ‘in-the-know’ insiders was felt to hold. Graham commented that it is “difficult for people [who have not had pregnancy losses] to know what to say, and they often end up saying ‘the wrong thing’” and Diane felt that “all [the people] that were there [at the face-to-face support group] had been through the same thing so understood exactly what I was going through and no one said hurtful things as they knew what to say and what not to say”. However, my point here is that the ‘sensitive insider’ versus ‘insensitive outsider’ distinction is not inevitable and can pertain more to the accumulated emotional intelligence/competency of the ‘consoler’ in relation to deciphering the specific preferences at that time/in that setting with the ‘griever’, rather than being about having personal experience or not of pregnancy loss *per se*.

Chapter 7: Bodily External and Contours

Introduction

The skin, “as a boundary-object” and “site of exposure or connectedness” (Ahmed and Stacey 2001 p2), far exceeds being merely an object of medical interest. Though the skin “does not simply contain the body” (Ahmed and Stacey 2001 p14), it occupies an important component in the deeply embodied, visceral experiences of pregnancy loss. The topic of bodily surfaces regarding skins and the additional adornments placed on/into these—such as clothing, jewellery and tattoos—have received considerable attention in recent decades in the scholarship of social science, arts and humanities (for example: Ebin 1979; Polhemus 1988; Rubin 1988; Sanders 1988, 1989; Benson 2000; Caplan 2000; DeMello 2000; Pitts 2003). Within this literature, it has been recognised that bodily surfaces constitute an important component in the production of human relationships and self-identity, often symbolising transition and status, used in various ways to express and communicate values and experiences. My focus in this chapter will be on the ways in which some participants’ skins, in terms of topographical surfaces and contours, feature in their narratives about pregnancy loss experiences. In foregrounding women’s external skins, I affirm the call to “theorise and reframe pregnant women [rather than solely fetuses] as the subjects of gestation [and, I add, of ended gestation]” (Tyler 2001 p81). In relation to pregnancy loss, this includes not only stories *about* the skin but also the ways in which stories can be told *through* the skin.

The skin is a topographical surface, covering and accommodating bodily contours and registering sensations including different kinds of touch concerned with movement, temperature and intent (Paterson *et al* 2012) which can affect at varying depths within- as well as between- bodies (Lea 2012). Simultaneously personal-individual in that it “holds the body together, delineating it as a bounded systematic wholeness, and holding organs, blood and corporeal fabric together” (Lea 2012 p33), the skin is also social as a site affected and engaged by inter-personal relations, alongside non-human actants and practices such as food and eating (Mol 2008). The ways in which visual marks or inscriptions and visibly altered contours can ‘communicate’ draws the theme of agency into consideration. Some skin-based body modifications are inadvertent and/or by-products whilst others are intentionally acquired, and the

connotations of skin marks can entail disconnect between the intended/preferable meanings of the ‘wearer’ and those ‘read’ by other individuals. Subsequently, some participants highlighted that their skin-based modifications were carefully negotiated with recognition and anticipation of insensitive responses from others, given the societal discomfort and/or disavowal of pregnancy loss. For some individuals, activities—including the acquisition, display/concealment and narration of skin-based modifications like tattoos—were thus carefully deliberated in a way demonstrating the skin as a locale “where boundary negotiations take place” (Benthien 2002 pxi).

This chapter will begin with an exploration of a prolific sentiment expressed about pregnancy loss, that of failure and blame in relation to one’s body, which I argue has potential implications for how stretch-marks may be conceptualised. Building on this, I will consider the physical girth/contours of bodies in pregnancy and pregnancy-loss in light of several participants’ comments, linking to maternity clothing and normative ideals of female corporeality. Refuting the stigmatising discourse of ‘failure’, I will then suggest that another conceptualisation of stretch-marks would be to perceive them akin to descriptions of memorial tattoos as appreciated reminders. Framing these examples of skin-based body modifications in a manner of reclamation furthers feminist politics of voice and recognises the agency/abilities of individuals within their various relationships, social networks and communities to engage in ‘meaning-making’, if desired. However, with the potential of this limited in actuality, I will discuss the theme of negotiating (in)visibility in relation to both actualised and anticipated encounters with others, such as friends and family as well as strangers, for memorial- tattoos and jewellery.

‘Failed’ Bodies

Pregnancy losses can be ‘ambiguous losses’ (Boss 1999; Cacciatore *et al* 2008) in which answers about the medical causes often remain unclear in addition to a profound emotional sense of the illogical and/or unfair nature of such events. Some participants in this research felt that their bodies had failed or that they were themselves to blame for the pregnancy loss occurrences, even when causes were disputed or indeterminable. ‘Failure’ is a highly emotionally-charged term referring to curtailed agency, an inability to determine outcomes, and often implicitly accompanied by a degree of moral culpability that one *could*

or *should* have been able to control events. When pregnancies have ‘unhappy endings’ (Layne 2003b), and because of perceptions around medical heraldry, the question of ‘cause’ often turns to the woman who was carrying the pregnancy and links to the vast array of prescriptive advice pregnant women encounter.⁵⁴ As mentioned in Chapter 6, prolific and prevalent advice is deployed not only in medical encounters but also in numerous, mundane, often uninvited engagements with family, friends and even strangers as well as actively sought online (Longhurst 1999, 2008). The content of such advice entails lifestyle/consumption, medical compliance and enduring commonplace beliefs regarding ‘maternal impressions’ (Markens *et al* 1997; Longhurst 1999; Abel and Browner 1998; Pollitt 1998; Morgan 1999; Lupton 2011).

Subsequently, as reflected in the comments of Anne that one’s pregnancy “becomes a bit [like] public property”, many women described feeling overwhelmed by the pervasive advice ‘offered’ and responsibilities placed on them. As Longhurst (1999, 2008) notes, this can lead pregnant women to feel that they are not seen by others to be a person in their own right, but rather have become perceived as a mere vessel, existing to serve the interests of the pregnancy they carry. There is often intense interpersonal interest, by known and unknown others, in sometimes quite tangible ways in engaging with the foetus (‘baby’) at the expense of the pregnant woman’s own wishes, privacy and consent. This notion is reinforced by: rhetoric such as the ‘maternal environment’ (Rothman 2007c; Tyler 2001; Michaels and Morgan 1999; Stabile 1998; Stanworth 1987); debates regarding ‘maternal-foetal conflict’ (Markens *et al* 1997) and ‘foetal patienthood’ (Casper 1999; Woliver 2002; Williams 2005); and visual imagery such as the infamous *Life* magazine photos by Nilsson of the ‘spaceman foetus’ devoid of reference to the uterus, let alone body/self (Tyler 2001; Fox 2000; Michaels 1999; Hartouni 1997, 1998; Duden 1993; Petchesky 1987). Spallone (1989) argues that women have been displaced as the core subjects of reproduction by a range of others, including that of the couple, embryos, the foetal patient, and medical practitioners. Simultaneously, however, there remains enormous onus on women—pregnant, but also planning

⁵⁴ This links to the suggestions by Lock and Kaufert (1998 p21) that the history of medicine has largely been narrated “as an heroic tale about the conquest of the enemy, whether it be human or nature – a narrative of progress, and of the betterment of humanity in general”.

or trying to conceive—to bear responsibility for their reproductive futures, including the health and outcomes of their pregnancies.⁵⁵

As noted in Chapter 6, many participants in the research made comments which attributed their behaviours, attitudes and bodies with considerable responsibility for ensuring the outcomes of a healthy, happy new-borns. In instances of pregnancy loss, such an expectation placed on oneself, and by others, is therefore called significantly into question. This can lead to individuals re-evaluating their actions for anything that could have jeopardised the pregnancy/ies, a psychological ‘busyness’ to pinpoint a cause, as well as deploring a lack of ‘intuitive’ bodily or ‘maternal’ awareness that ‘something was wrong’. Lara, for example, emphasised that “I don’t do drugs or I don’t smoke, I didn’t drink that much either so I don’t really know what I did wrong”, before tentatively suggesting that ‘over’ plucking her bikini line could have caused her miscarriage.⁵⁶ Subsequently, some women internalise an association with ‘failure’ and culpability which seeps into their identification as ‘mothers’ and ‘women’. Such feelings are testament to the “enduring centrality of motherhood to women’s sense of self and to women’s sense of individual responsibility for the fate of their pregnancies” (Kevin 2011 p854) and links also to the ways in which women without children, voluntarily and involuntarily, have long been

⁵⁵ In discussing reproductive responsibility, Daniels (1999 p88) argues that “[c]ultural assumptions about male invulnerability and female susceptibility have deeply shaped the nature of scientific research on fetal risks”. Whilst drawing attention to the biological and social dimensions of paternal impacts (like exposures to viruses/toxins affecting sperm and the social context of paternal actions including around forms of abuse and encouraging addictions), Daniels (1999) discusses gestation as an additional component in entailing body-labour as well as genetic material for pregnant women over their partners/impregnators (see also Hird 2007 on pregnancy as ‘maternal gifting’). Whilst gestation is recognised as a more direct route of exposure for foetal risk, Daniels (1999) also highlights an array of ways in which placing sole responsibility onto pregnant women, especially when this is accompanied by punitive treatment, negates the more complex situation around foetal health which includes, for example, issues of environmental and occupational/workplace exposure to toxins.

⁵⁶ Lara explained: “it does hurt when you pull out a hair from like your private area and things like that, I don’t know if there is a nerve that is connected to where it [embryo] is and maybe could have caused it... I don’t know”. Such hesitancy in disclosing this pertains, I argue, to simultaneous concerns that the suggestion might be “a bit too silly to mention” but also fear that might be a culpable action, both possibilities being subject to negative judgments.

deemed pathological for ‘failing’ to confirm to societal expectations about reproductive norms (Hird 2003; Letherby and Williams 1999; Tonkin 2012).

Several participants commented that the medical language used by professionals about pregnancy loss caused upset and could amplify feelings of ‘failure’.⁵⁷ These comments resonate with Martin (1987, 1990) regarding the repetitive use of ‘failure’ and ‘waste’ discourses in describing women’s bodily processes as found in medical texts. Helen explained that:

terms [such as ‘failed pregnancy’ and ‘spontaneous abortion’] are also very negative, and made me feel worse about myself – in that my body had ‘failed’ or I had ‘failed’. It added to my sense of guilt. I didn’t feel guilty in the way I think lots of others do – when they over analyse every alcoholic drink they had or try to find causes based on their own actions – but just in terms of me, I had failed to support this baby to grow inside me.

Some participants reported encounters with known social others which had brought a sense of having ‘failed’—at the pregnancy, as a mother, as a woman—acutely to the fore. Whilst the origin of the term ‘stigma’ derives from physical branding on the skin to visually demarcate someone as disreputable, stigma and accompanying feelings of shame, blame, guilt and failure can be evoked in many ways (Goffman 1963). As Charmaz (2002) notes, seemingly mundane moments as well as unusual instances can produce lasting stigma with impacts on self-identities. For example, Caroline recalled the stigma induced by persons who (physically, socially) distanced and differentiated themselves from her:

I had friends crossing the street after my third miscarriage [...] they’d cross the street to avoid me, you know, because I think they just didn’t have a clue what they were going to say and I found that very hurtful, you know. I thought well it’s not really my fault.

Additionally, as for Siobhan, discussed in Chapter 4, stigma can be internalised and anticipated with regards to encounters which may never materialise but nonetheless detrimentally impact one’s own sense of identity and esteem.

⁵⁷ Some medical language is particularly triggering, sometimes owing to the historical origins, such as the tendency to refer to miscarriage as ‘spontaneous abortions’ (Letherby 1999; Jonas-Simpson and McMahon 2005; Frost *et al* 2007; Henley and Schott 2008).

As a result of the prevalent notion that pregnancy losses are demonstrations of 'failure', since women's identities and bodies remain largely tied to reproductive/sexual capacities as they have at numerous historical periods (Friedan 1963), unintentional topographical marks such as stretch-marks might also be similarly associated with connotations of 'failure'. Several participants conveyed a sense in which various changes to their bodies resulting from pregnancies that had ended in loss and/or their management, such as by surgery, had impacted on their bodily-esteem and sense of self-worth. There were several occasions when participants spoke of low self-worth and body-images, for which I felt impelled to intervene (see also Methodology chapter on interview encounters and consolation). The following email interview exchange with Victoria entailed the discussion of bodily changes such as weight-gain for which I sought to negotiate and hopefully alleviate some of the accompanying suffering pertaining to her sense of 'failure'. Victoria had experienced two miscarriages (one ectopic) in close succession only a few months prior to research participation, with continued ramifications. This included three itchy scars following a laparoscopy which had required the removal of one fallopian tube and she was extremely apprehensive about possible future pregnancies:

[excerpt from Victoria to Abi]:

I have no self-esteem! I do not work and am home with my 18 month old every day, I would not have it any other way but I do think it has affected my confidence. Plus I have put on a LOT of weight over the past year and that has had a very bad effect on my confidence too, I do not want my partner to have to be seen out with me as I look so awful

[...]

[excerpt from Abi to Victoria]:

I'm so sorry to hear about the ongoing difficulties and to hear how badly affected your confidence is at the moment. I hope you won't mind me saying so- but in the course of doing this research, I've found that the feelings you express (about lowered confidence, feeling bad about things that happened during the miscarriages and feeling unable to speak to anyone for fear of 'burdening' them) is unfortunately something that many other women feel also.

Sometimes it can help to know that you are not alone in having those kinds of feelings[.]

Stigma and Skin-based Marks

For many, the enduring distress of pregnancy losses far exceeds the actual events of occurrence, having potentially both emotional and material impacts in their ongoing lives. Retaining the traces of past experiences, skins are matter both *object-like* in terms of amenability to inscription and *lived*. As Ahmed and Stacey (2001 p2) comment:

[s]kin is temporal in the sense that it is affected by the passing of time or, to put it differently, it materializes that passing in the accumulation of marks, of wrinkles, lines and creases, as well as in the literal disintegration of the skin [...] The skin is also spatial in that it expands and contracts[.]

I suggest that the disintegration of the skin is also spatial, constantly undergoing 'loss' and 'death' as surface cells are shed and deposited with inter-personal skin-to-skin touch entailing "[t]he dead you [...] being rubbed away by the dead me" (Winterson 1996 p123). Experiences, internal and external, can leave visibly overt skin-based marks and sensorial alterations. For instance, Kristeva (1980 p237) vividly captures pregnancy processes in her description: "[c]ells fuse, split, and proliferate; volumes grow, tissues stretch, and body fluids change rhythm, speeding up or slowing down. Within the body, growing a graft, indomitable, there is an other". Through creating and sustaining embryos/foetuses, women's pregnant bodies undergo a plethora of physical as well as potentially emotional changes which, as we have seen, can be interrupted by pregnancy loss at numerous points and in numerous ways.

The deeply embodied, visceral experiences of pregnancies and pregnancy losses can leave marks, including on/in the skin, which may be imbued with various connotations and meanings. For instance, Benthien (2002 p3) notes the ways in which the skin has often been imagined as "a fragile parchment unable to protect against violence". This notion of fragility and vulnerability resonates with the emotions reported by many participants of feeling out of control, frightened and uncertain as to the practicalities and meanings of their pregnancy losses. Davidson (2008) and Murphy (2009) both argue that the

bereavement mantra prevalent until the onset of ‘continuing bonds’ theories in the late 1990s (Valentine 2008) posited that it would be ‘best’ to forget/move on from stillbirths and, I add, other pregnancy losses. Whilst there have been improvements, including in hospital best practice protocol (Davidson 2007, 2008), pregnancy loss grief is still often subject to silence and sequestration (Frost *et al* 2007). However, it is not only the emotional intensity of pregnancy losses but also the presence of physically ‘telling’ marks which are potentially negated, as well as internal, contour, flow-based changes in/on/of the body (Murphy 2009). In this context, stretch-marks—as unintentional and, within wider western culture, undesirable outcomes of changes in bodily girth—could be seen as inscriptions also imbued with ‘failure’ and ‘fragility’ after pregnancy losses.

Stretch-marks are caused when the dermis layer of the skin is strained as the body expands, whether through pregnancy, growth spurts as in puberty or otherwise changes in weight. The skin heals, leaving jagged lines clustered around corresponding contours—most often the breasts, stomach, hips and thighs—which often, with time and/or treatment, pseudo-assimilate to the surrounding skin pigmentation whilst retaining a sheen. The extent of stretch-mark coverage in terms of quantity and noticeability varies according to a range of factors. Not all participants in the research developed stretch-marks during pregnancies that were later lost, sometimes because pregnancy loss occurred prior to significant changes in body size or because of different degrees of skin elasticity. Additionally, some participants noted that the bodily experience of previous pregnancy losses had left little to no obvious bodily changes or marks at the time/shortly afterwards but later discovered visual and/or sensorial impacts in subsequent pregnancies. Regarding her first pregnancy which ended around 21 weeks, Gemma explained:

I didn’t have a massive bump – I think your muscles are much tighter in the first pregnancy. I guess those lasting marks probably kind of remain though... the way my body responded to the second pregnancy and the third pregnancy, so labour was easier the second time because my body had already been through that process. My muscles were probably already looser so I probably

had a *bigger* bump with [second pregnancy] than I would of done and then got stretch-marks.

The topic of pregnancy bumps links to Colls' (2012) work on relations between vision and touch concerning bodily surfaces and flesh. Colls (2012 p233) offers a reading of the nude female bodies of Jenny Saville's art "premised upon distinctly geographical relations of proximity and intimacy in ways which surprise and challenge our understandings of what a fleshy body can do". Rethinking the relationship between vision and touch through the work of Merleau-Ponty and Irigaray, Colls (2012) highlights intra-body touching and the ways in which this can be hidden from view. Citing Irigaray's (2004 p139) examples of intrauterine life and the sexed specificity of labia lips which "touch themselves in her, within and inside women, without having recourse to seeing", Colls (2012 p242) describes thighs pressed together in Saville's painting *Propped* as that which "hints at and yet hides that which is hidden between her legs". In a similar manner, pregnancy bumps can be understood to visually demarcate through pronounced contours whilst simultaneously concealing and yet, as discussed in Chapter 3, interior 'happenings' are also sometimes intensely and abruptly 'present' through felt sensations like foetal movements.⁵⁸ The topic of skin, stretching to accommodate the physiological contours of pregnancy, also highlights maternity clothes as a kind of proxy skin.

As Longhurst (2008) argues, clothes are a site at which subjectivities are produced in and through social interactions, with maternity clothing occupying somewhat of an unusual position. Owing to the limited temporality of use, even in full-term pregnancies, maternity clothes subsequently tend to be highly mobile, circulating between family members, friends and neighbours (Gregson and Beale 2004). Maternity clothes evidently relate to changes and/or pre-emptive changes of the physiological pregnant body and link closely in various ways with esteem (Reinharz 1988). In terms of purchasing new maternity wear, Longhurst (2008) comments that some pregnant women are reluctant owing to reasons of costliness given limited temporality of use, disdain towards the styles available and/or ambivalence towards 'pregnant corporeality' such as discomfort with bodily changes regarding 'bigness'. However, in the context of

⁵⁸ In addition, discussed in Chapter 3, medical-technological visualisations of uterine interiors such as via ultrasound can be seen to enact a form of "skinning" (Duden 1993 p7).

pregnancy loss, there can be additional aspects associated with the materiality and emotionality of maternity clothes. Several participants described the excitement about obtaining maternity clothes as balanced against a wish to be cautious and restrained before they physically required the clothes and/or had reached particular gestational stages. Some women interviewed conveyed that wearing maternity clothes ‘legitimately’, when their bodies physiologically required with (hopefully) a ‘successful’ pregnancy, was a kind of status marker, participating in a much-desired ‘rite of passage’ of ‘becoming a mother’ (Clarke 2004). For those whose pregnancy losses occurred prior to acquiring or wearing maternity clothes, missing out on having and shopping for such apparel can be an additional component in their meanings of ‘loss’. Others, following their pregnancy losses, were left with unused maternity clothing and/or other baby paraphernalia, such as cribs, which they either stored in their homes or returned to the shop purchased from.

It was not always the lack of opportunity to have or wear maternity clothes lamented, but sometimes the necessity to continue wearing these whilst the physicality of the body in terms of girth/contours retained the appearance of pregnancy following loss. In such instances, maternity or ‘bigger’ clothes derisively highlighted one’s body as a ‘failure’. Natalie described having to continue wearing maternity clothes as her physiological circumstances slowly resumed to normal. Her latter miscarriage of two was managed medically by several ERPCs as one operation unintentionally causing a painful false uterine passage, with ongoing complications at the time of interviews months later:

I’d already put on weight and so actually when you miscarry, the last thing you want to be doing is wearing your bigger clothes but they’re absolutely the only clothes you can get on at the beginning [...] so that is very depressing. That you’ve been pregnant, it’s not worked out, you’re not having a baby but yet you still can’t get in your pre-pregnant clothes as it were, you’re still wearing these larger sized clothing but for absolutely nothing at the end of it other than upset and hurt [...] [Eventually] I was determined that I didn’t want to wear the big jeans so I just put them away and I squeezed into my other clothes {laughs}

Several participants made disparaging or contemptuous comments about their pregnancy loss stretch-marks and/or weight-gain. These changes, concerned with the surfaces and contours of the body, could be seen as imbued with notions of ‘failure’ as a result of pregnancy losses which are typically disregarded as trivial or shameful experiences in wider society. However, I suggest that contextualising dislike, aversion and embarrassment of such bodily features/changes within wider normative ideals of female corporeality offers another explanation for participants’ comments. Linking to the statement that “whether externally bound or internally managed, no body can escape either the imprint of culture or its gendered meanings” (Bordo 1990 p109), feminist scholarship has considered the ways that women have long been subjected to beautification expectations as a form of disciplining. For women, the flesh—in terms of appearance, consistency and mass—occupies a central concern for (self)regulation and modification as a “constant, intimate fact of everyday life” (Bordo 1993 p17). Subsequently, aversion towards stretch-marks, cellulite and larger bodily-girth described by participants can be conceptualised not only through the lens of ‘pregnancy loss’ *per se* but rather of pregnancy changes and female bodily ideals more generally. Although in pregnancy loss the ‘reward’ (baby/ies) for changes to women’s bodies are arguably absent, the significance of body image is a theme consistent throughout many women’s lives in contemporary Western societies. As such, women who have live births/living babies often also describe feeling intensely dissatisfied about aspects of their ‘post-baby bodies’ (Earle 2003; Upton and Hann 2003; Jordan *et al* 2005; Longhurst 2008; Clark *et al* 2009).

Preoccupations with ideals of female corporeality centred around slim, taut bodies and pristine skins are one of the most powerful strategies of normalisation in Foucauldian terms of (self)disciplining (Bordo 1990). Drawing on Chernin’s (1981) term ‘tyranny of slenderness’, Bordo (1990 p90) argues that bodily ideals continue to recede from realistic attainability and that, for many, “to be slim is simply not enough – so long as the flesh jiggles”. In relation to both pregnancy losses and pregnancies previously or subsequently resulting in living offspring, several participants described a ‘need’ to lose weight in order to ‘return’ to their pre-pregnancy body states. In addition, there were comments by some participants that they would feel uncomfortable in spaces, such as when out with their partners, as for Victoria, or at the swimming pool where strangers

might see their stretch-marks. In relation to body size/weight, there is an expectation that one must work, with considerable time, energy and/or money, to 'control' and 'rectify' unruly bodies within consumerist capitalism (Bordo 1990). Whilst surgical and topical treatments are available to minimise stretch-marks, no participants reported using, or planning to use, these. Rather, both Anne and Rosie conveyed a sense of acceptance whilst somewhat playfully commenting about their 'bikini bodies' being affected. Rosie commented: "I've got the scars on my body from the ectopic which are still very obvious every time you look in a mirror and I'll now never wear a bikini, that's for sure – so there goes my bikini modelling career {laughs}". Others, however, found the accumulated presence of such marks on the skin devastating, such as Carla who had acquired the majority of her stretch-marks during her first pregnancy prior to two miscarriages and three elective terminations:

Carla: my arse... nobody sees my arse, I hate it, it's not just stretch-marks, it's like this [corrugated] radiator, my stretch-marks are like dented into my arse. I've got stretch-marks on my legs, all over my boobs, all over my belly erm... I've got a few on my back, I even ended up with some on my ankles – I'm absolutely covered [...] [During the pregnancy] I ate loads, but I did find out from the midwife – the younger you are [the more stretch-marks likely], because your skin hasn't stretched and hadn't stretched on my back, I ended up with loads

Abi: did you get any stretch-marks after the other pregnancies?

Carla: I got a few off... my first miscarriage because at 12 weeks, I already had a tiny little, not a lot, bump and my arse had expanded quite a bit so I ended up with stretch-marks I never had before just there [stomach] and some there, only a few though, but I think it's probably 'cos it [the pregnancy] didn't go far enough on

Abi: do you feel differently about the stretch-marks from the miscarriage than those from your pregnancy with [living child]?

Carla: I hate them all equally {coughs} I just hate them because I'm [mid-twenties] and I look like a 90 year old, like want to take your clothes off? Oh no! It's like I wouldn't ever wear a top like where you wouldn't wear a bra and I will not wear dresses, skirts or anything, I wear jeans and trousers and that's it.

Whilst other individuals may feel differently, Carla suggested that her feelings towards particular stretch-marks are not tied to the specific causes of the bodily changes (pregnancy loss or not): “I don’t feel differently for the different ones [stretch-marks] I’ve got, they’ve all just kind of merged into one”. Rather than viewing some of her stretch-marks as embodiments of ‘failure’ (when miscarriage occurred), it appears that the aesthetics of *all* of these, in disrupting the smooth, blemish-free skin ideal, caused Carla to feel so negatively and subsequently adopt cover-up dressing strategies. Such comments support the notion that, for some individual at least, it is not necessarily the outcome of pregnancy loss *per se* causing them to feel unhappy towards bodily changes such as skin sagging and stretch-marks. Upton and Han (2003) note that the postpartum body tends to be scrutinised in a different way to the ‘public’ pregnant body, with the former involving broader ideologies about female body norms. As such, the reasons for some participants’ ambivalent body images may pertain to dislike of bodily changes in pregnancy/following birth generally (Earle 2003; Upton and Han 2003; Jordan *et al* 2005; Longhurst 2008; Clark *et al* 2009) in line with broader cultural normative ideals about women’s bodies (Bordo 1990, 1993; Duncan 1994; Frost 2005).

Reclamation and Appreciated Reminders

Far from monolithically denoting ‘failure’ in terms of pregnancy loss or otherwise, stretch-marks are open to a number of interpretations, including those resonating with memorial tattoo narratives of appreciated reminders. These two forms of skin-based body modification seemingly entail divergences: whilst stretch-marks are seen as unintended and unwanted side-effects of changing body sizes/weight, Harlow (2005 p42) comments that “[p]erhaps the ultimate form of inscription is the self-inscription of tattooing”. Yet, I argue that to pit them as oppositional would be an impoverished reading since there is agency evident in the ways that participants ascribe meaning and purpose to their stretch-marks, similar to those found in memorial tattoo narratives. There is a need to expand a notion of ‘agency’ that goes beyond the initial intention or cause of a skin marking, to think about the abilities of individuals, and their various social support networks and communities, to engage in ‘meaning-making’, emphasising the potential for multiple understandings of the physical inscriptions on and of skins. This foregrounds Benthien’s (2002 p12) comments

that “the skin in and of itself has no intent, even if it may very well express intention. One can communicate with the skin, and one can communicate about the skin”. Thus, research participants engaged in “narrating *with* their bod[ies] and *of* their bod[ies]” (Oksanen and Turtiainen 2005 p113) in relation to memorial tattoos and stretch-marks, demonstrating a plethora of possible meanings, interpretations and styles of communication.

Anne highlighted how skin-based modifications can be valued by the ‘wearers’ as appreciated reminders in relation to the stretch-marks she developed during a pregnancy which ended in stillbirth:

Abi: are you bothered more by the stretch-marks being more kind of visible to other people?

Anne: well because I’ve never really had a bikini body {laughs} ha nobody ever really sees them, it’s only my husband and me that really see... to be honest, now that we’ve lost him... I don’t mind them at all [...] So when that [PUPPP]⁵⁹ started in my stretch-marks I really, really hated them but now we’ve lost him it’s, it’s just a, it’s, it’s, it’s, a mark on me, a PHYSICAL mark on me that I had him which is good for me because our life is very much the same as it was before, but it’s dramatically different as well so because we have no other children, you know, our days are much the same as they were before. We don’t have to book a babysitter when we go out on a night, there’s nobody making mess in the house but us, all the things we thought would have an impact on our life hasn’t because we don’t have him

Abi: hmm

Anne: so our lives in some ways are very much the same as they were before so for ME, it’s incredibly... wonderful to have reminders that we had him and that he existed and one of those reminders is my stretch-marks

Abi: yeah

Anne: so, I don’t mind them at all.

⁵⁹ Pruritic Urticarial Papules and Plaques of Pregnancy (PUPPP) is a skin rash experienced by some women during pregnancy; it tends to be extremely itchy but is otherwise harmless.

These sentiments resonate with the descriptions given in research generally on memorial tattooing (for adult bereavements) and those marking other/additional ‘traumatic’ experiences (Springer 1997 on violence in adolescence; Brouwer 1998 on HIV+ status disclosure; Otte 2007 and Gentry and Alderman 2007 on post-Hurricane Katrina). Indeed, Western elective tattooing in general has highlighted the centrality of self-expression and supportive functions in relation to the practices of acquiring/having these skin marks (DeMello 2000; Kosut 2000; Pitts 2003; Oksanen and Turtiainen 2005). As Oksanen and Turtiainen (2005 p128) argue “[t]attoos function as shields for subjectivity when everything else seems uncertain”, suggesting that the physicality of a tattoo—but potentially also the process, including pain, of being tattooed—can help console individuals regarding the unpredictability and instability of the future. Tattoos can ‘ground’ acknowledgement by making tangibly present the trace of an event or person in one’s life. In this way, tattoos can “serve as memory maps and tool kits helping subjects structure their experiences” (Oksanen and Turtiainen 2005 p120-121) which, I suggest, is also the case for Anne’s stretch-marks.

Shortly before our first interview, Anne also acquired a small memorial tattoo on her wrist of a printed image from a baby sleepsuit that she had bought and her stillborn son had worn. The image and meaning of the tattoo connected with a wider context of care and recognition in which family members also participated. In addition to noting the support provided by both her parents and parents-in-law, Anne spoke about valued time spent with her sister:

Anne: she actually went with me to get a tattoo in memory of my son so... she, my sister, is covered in tattoos so she went with me as it was my first one {laughs} [...] I’d sort of decided to get a tattoo so that, apart from the stretch-marks I have {laughs} of which I have many {laughs} I’d have a permanent... reminder, which is an odd thing to say because I’m not going to forget him, but something, a permanent mark really on my body that’s about him [...]

Abi: yeah... did your sister get a tattoo as well? Did she get something also in memory of your son?

Anne: no she didn’t, no, but my sister really surprised me actually,

she doesn't have children, she's really, she was really, she's never really shown an interest in children, she didn't want to have any of her own but she was just so... chuffed about us having him, she was so excited and she'd actually bought a little outfit for him, a little {laughs} pirate themed outfit, don't ask

Abi: {laughs}

Anne: {laughs} a little pirate themed outfit for him and she texted me a few weeks ago and told me that she was going to keep the little outfit and she was going to, this might sound a bit strange, but she was going to get like a teddy bear or something like that and put the outfit on [that] so she kind of has a permanent reminder of him really in her house

Abi: yeah

Anne: which... now I'm saying it out loud, it sounds a bit weird {laughs}

Abi: no, not at all

Anne: but I was touched by it because... you know, we don't talk a lot or we never really used to talk a lot in depth about things but she's been completely brilliant about this, very open to talking to me about things, very sad herself about what's happened and, you know, so actually one of the massively great things is that it's brought us all together much more as a family and my mum has really got to know my mother-in-law and father-in-law a lot and she never did before, they'd hardly ever seen each other and they've [now] spoken quite a lot on the phone so it's really kind of brought us a lot more together.

As Layne (2000) notes, those who experience pregnancy losses often encounter the 'realness problem' in relation to the socially prevalent notion that a 'real' baby did not exist and is not worthy of grieving or memorialising. A range of 'baby things' can be drawn on to resist this cultural denial of pregnancy loss, including 'index' material objects such as locks of hair, worn clothes and foot ink prints which retain qualities of bodily traces of the deceased (Layne 2000). Thus, without a tangible embodied social identity, material objects can be used by parents to articulate the pregnancy loss "as the death of a person rather than the outcome of an unproductive pregnancy" (Bleyen 2010 p84). For

Anne, her stretch-marks provided physical evidence of her relationship with her son and the memorial tattoo, which entailed sharing the process of acquisition in the company of her sister and the significance of worn baby clothes, offered further recognition. As such, these skin-based marks and their wider context, including the unworn baby clothes kept by her sister, resonates with continuing bonds theories in which Anne's family were 'brought together' to include the living and deceased (see also Chapter 8).

Since, for each person, "[t]he choices I ma[k]e in any current moment will depend on the story line I take myself to be living out" (Davies 1992 p69), participants demonstrated abilities to forge preferable narratives with meanings attributed to their stretch-marks and memorial tattoos. The diversity of narratives through which stretch-marks could be read or seen to 'speak' highlights Ahmed and Stacey's (2001 p6) comments that "although skin may have a testimonial function, the act of bearing witness to trauma, injustice, violence and the pain of others cannot involve simply the transformation of skin into voice". Rather, the meanings of skin-based marks for individual 'wearers' vary and cannot be assumed decipherable without their elaboration, such as those provided in the research interview conversations. As Ellis and Bochner (1992 p79) highlight, "[t]he act of telling a personal story is a way of giving voice to experiences that are shrouded in secrecy". By speaking about their experiences and related tenets such as stretch-marks, I argue that participants engaged in processes of integrating these with their lives as well as breaking the cultural 'silence' around pregnancy loss (Layne 2003a, 2003b). Given the social attitudes towards pregnancy losses, the approach described by Anne can be understood as a reclamation narrative which counters that of 'failure' and refuses the imperative socially-implied expectation to 'move on and forget'.

Whilst 'failure' is one possible storyline linking to shame and silence, another is that of 'reclamation' in which skin-based marks as material 'evidence' could be cherished for evoking memories and potentially functioning as kinds of embodied memorial sites. As discussed in Chapter 5, the site of death for pre- and intra- partum pregnancy losses can be understood as the reproductive, interior body. Hirsch (1989 p166) argues that "[n]othing entangles women more firmly in their bodies than pregnancy, birth, lactation, miscarriage, or the inability to conceive" and it is therefore significant that the body is also

sometimes used as a site to ‘ground’ memory and enact memorialisation. Though certainly true that stretch-marks and memorial tattoos, when seen or felt, can invoke sadness regarding losses—of the anticipated baby/babies and/or multiple hopes, dreams and expectations—we have seen that such topographical marks can also be experienced as positive, heart-warming facilitators of remembering. Thus, singular and collections of accumulated skin-based modifications, including stretch-marks and memorial tattoos, were appreciated by some participants precisely because they can “remind their bearers of the durability of human relationships as well as the hardships encountered in life” (Oksanen and Turtiainen 2005 p124). By embracing counter-narratives to that of ‘failure’, such as those which reiterate the shared bodily history of pregnancy with wished-for ‘baby/ies’ and ongoing ‘bonds’ following losses, some participants demonstrated that skin-based modifications like stretch-marks could partake in producing and maintaining the affirmative meanings they wished to convey.

Visibility and Legibility

Participants described negotiating aspects of visibility and legibility, recognising their skins and thus skin-based modifications/marks to be simultaneously private (self) and public (exposed to others) as a “medium of communication with the world” (Benthien 2002 p23). It was appreciated that “skins, as well as other bodily surfaces and folds, expose bodies to other bodies, rather than simply containing ‘the body’ as such” (Ahmed and Stacey 2001 p4) and that, being an interface between self and world (Benthien 2002), skins involve “dialogue[s] between the body, self-identity and society” (Kosut 2000 p99). Participants reported different experiences and encounters regarding both known and unknown others in relation to their external skin marks like memorial tattoos. It was also remarked that there are times, places and situations where this visibility and legibility is more carefully guarded against. Given the parallels in participants’ narratives, I will also explore the use of memorial jewellery as an example of valued material objects which, in some circumstances, were worn and thus constituted highly visible stimuli for conversations (Riches and Dawson 1998).

Since “tattoos compel one to gaze” (Kosut 2000 p82), ‘wearers’ may seek to pre-emptively manage undesirable gazes from others.⁶⁰ The visual-textual legibility and location on the body of tattoos were important considerations, with some participants weighing up a desire for high visibility against risks that this may incur. Several participants described a sense of enjoyment from glimpsing and remembering the meanings behind their tattoo(s) as well as appreciated inquiry from others. Anne’s memorial tattoo was valued as a ‘permanent’ reminder on her body about him and in a pseudo-visible, semi-private location on her body:

[the tattoo is] on the inside of my wrist, so that I can see it when I want to and also, you know, people might ask me about it and that’s okay because... then I’ll be able to tell them, you know, that I have a son.

Such a comment reverberates strongly with Oksanen and Turtiainen (2005 p128) that “[t]attoos articulate as memory maps written in flesh that enable life stories to be told”. However, several participants also expressed concerns that memorial tattoo visibility might attract unwanted and intrusive inquiry, exposing them to situations where they felt that they might be pressured into explaining the tattoos and/or subject to hurtful comments. Of the participants in the research, Anne had chosen the wrist whilst Fiona and Diane had both chosen the space between their shoulder blades for their memorial tattoos; all functioning as relatively flexible bodily locations for negotiating visibility (‘on show’ or not) given the predominant climate in their country of residence of the UK.⁶¹ Narratives about the decision-making processes around acquiring the

⁶⁰ Although not directly mentioned by any participants here, it has been noted in academic literatures that tattooed women often face additional issues regarding stigma compared to their male counterparts (Atkinson 2002; Pitts 2003; Mifflin 2013).

⁶¹ Owing also to cultural norms about propriety and ‘sexually’-delineated locations of predominant occurrence (breasts, hips, stomachs, bottom), stretch-marks were unanimously deemed overtly private and their visibility to most others disagreeable. Thus, stretch-marks were not talked about as skin-based modifications which participants made deliberate attempts to ‘show’ or ‘allow to be seen’. Instead, these tended to be subject to concealment such as by Rosie and Anne, regarding the end of their ‘bikini bodies’, and Carla who described clothes she would (jean/trousers) and wouldn’t (skirts, dresses, bra-less tops) wear in order to hide her stretch-marks and contain looser flesh.

tattoos often included issues such as anticipated responses, from both known and unknown others, and issues of the design, size and style of the tattoo.

In weighing up the benefits and risks of visibility and legibility in relation to memorial tattoo acquisition, some participants' narratives retained significant tensions. Reflexive about intentionality, motivation and the degree to which subconscious factors may have participated, Fiona spoke about her choice of a tattoo in another language to mark an early miscarriage:

[the tattoos are] all personal, I don't really want anyone reading them and knowing what they mean (which is a double standard if anything, if I didn't want anyone knowing then I should never have gotten a tattoo in the first place)[.]

Such an account reflects an ambivalence between a tattoo as able to provide recognition and acknowledge losses in a way which "situates pain and charts life experiences" (Oksanen and Turtiainen 2005 p127) whilst attempting to minimise a sense of overexposure. Both imperatives tend to be strongly felt and, it seems, often remain somewhat unresolved. The act of literally inscribing the existence of pregnancy losses onto bodies within a society which tends to socially and medically disavow these events is highly significant; however, within such a context where pregnancy loss is largely relegated as a 'private' issue, "[t]he more intense the need to veil the innermost parts, the greater the fears that develop about being involuntarily exposed" (Benthien 2002 p31). This has resonance with my discussion in Chapter 6 regarding the tensions between dispersing awareness of pregnancy loss and protecting individual privacy. Another aspect that Fiona employed for negotiating this tension between the simultaneously private-public nature of her tattooed skin was careful verbal narration. This strategy began from the moment of the tattooing process:

[t]he tattooist himself did actually ask what it meant as he was curious because I'd done the design myself but to be honest I gave him the non-committal 'it's personal' reply. It was during that period of time where I didn't want to speak about it.

When I asked her how the tattooist reacted, as well as any other individuals to whom she had refused elaboration of the tattoo meaning, Fiona said:

[p]eople's responses are usually quite similar, they usually tend not to push any further and just leave it at that [...] When I say that 'it's personal' I try to respond in a way that they know that I'm not trying to be rude or cutting, but just that I honestly don't want to explain or go in to it. The people that really know me, know that if I want to talk, I'll offer up the subject myself but to push me in to talking about it when I don't want to won't achieve much.

Hence, when the tattoo is visible on “a rare night out”, Fiona has “had a few questions asking what it means [and] I usually tell them the same thing[,] that it's personal[,] and people thankfully don't really push the subject”. In confidently adopting this approach of firmly but politely rejecting the invitation to explain the tattoo to unknown others, Fiona is able to dress without feeling a need to cover up her tattoo(s).

Whilst location and aesthetics of skin-based markers are relatively fixed, subject to the possibility of cover up by clothes/jewellery, their meanings and emotionalities are subject to alteration. “Since life is constantly changing, the tattooed body cannot be static” (Oksanen and Turtiainen 2005 p122) and meanings can shift or fluctuate with re-evaluation across time and space. This does not mean, however, that previous meanings simply evaporate since the skin is “both already inscribed, or marked, and is always yet to be inscribed” (Ahmed and Stacey 2001 p14), in processes of becoming and changing. Ahmed and Stacey (2001 p15) acknowledge that although skins can “acquire new meanings, new forms, new shapes [...] [they still carry] traces of those other [including historical] contexts in the very living materiality of its forms”. Diane had a total of three tattoos at the time of our interviews, the most recent from about five years ago marked her experience of seven miscarriages. She acquired her first tattoo prior to any of the miscarriages and her second tattoo following five miscarriages, prior to conceiving her second living child. This second tattoo is of an angel, a symbol particularly prevalent within pregnancy loss imagery (Layne 2000) and although Diane found affinity with through cherub ornaments representing her “lost babies”, she did not perceive this to be a memorial tattoo. Instead, it was chosen on an aesthetic basis: “I had the angel one just because I liked it[,] no reason behind it”.

It was Diane's third tattoo which she described as her "baby loss" one, acquired following two additional miscarriages and the birth of her third living child. This tattoo again featured imagery associated with memorialisation generally and pregnancy loss specifically: hearts, cursive font, angel wings and halos. This tattoo, along with a number of cherub/angel and teddy bear ornaments (see Chapter 8), took on particular significance after Diane was required to disassemble her informal memorial garden when moving house. Though her memorial tattoo was rarely visible, except on holidays to warmer climates, to the extent that her preadolescent daughter was unaware of the tattoo or miscarriages, it held enormous personal value:

[I] haven't really been asked about it to be honest but if [I] ever was [I] would be more than willing to tell them what it means to me, it means my babies are always with me even if they are not living, even though they were never born they were still my babies[.]

Layne (2000) implies that the lack of pregnancy loss mementos can underpin the social denial of such losses and their grief legitimacy. Subsequently, proxy symbols of angels and footprints are often used to invoke thoughts of the wished-for children (Layne 2000). Diane explained her reasoning:

I wanted the tattoo done for me to feel that my babies are always with me, as we who have early mc [miscarriages] don't have anything to remember our babies by[.]

With the 'disenfranchised grief' (Doka 2002) of many pregnancy losses and a lack of objects which had physical connection/contact with her to-be-babies, Diane utilised the imagery of angels in rendering her own material skin a memorial location: a place literally 'touched', by her pregnancies as well as the tattoo needles and ink, and marked as a testament to her experiences.

Whilst jewellery tends to be a less enduringly part of the body compared to stretch-marks, scars and tattoos, the close proximity of these objects to/on the skin resonates with tattoos in various ways.⁶² Both tattoos and jewellery can

⁶² Although minimising/concealment products and laser-removal treatments are available, stretch-marks, scars, tattoos can be seen as being/becoming permanent parts of the skin. In

‘add’ to or otherwise decorate the skin, altering it to varying degrees of adornment durability. Memorial jewellery has a long history in the UK, entailing different trends and customs of which the Victorian era famously consisted of complex and prolific requirements for socially-apt mourning attire (Taylor 1983). In relation to pregnancy loss, motifs of angels/cherubs as well as foot prints featured in pieces of memorial jewellery that some participants had been given or purchased. As Layne (2000 p338) states, memorial jewellery “serves not only to constitute that which was lost as ‘a child’ but also, just as importantly, the woman as ‘a mother’”. In contrast to some material objects associated with bereavement generally, such as graveside flowers, and those specifically in relation to pregnancy loss such as balloons (Layne 2000), lit candles (Bleyen 2010) and bubbles (Davidsson Bremborg 2012) – memorial jewellery can be seen as a ‘hard’, lasting good (Layne 2000). For instance, Jane bought a bracelet from Ebay “made of beads with a little silver pair of angel wings which was made specifically for sufferers of miscarriage”. However, Jane rarely wore the bracelet because her young son “took quite a shine to it and liked pinging the beads” and she felt her husband would prefer not to see the visual reminder of the bracelet since “[his] approach to life is that if he ignores something bad then it generally goes away, or at least is lost underneath the surface”. Whilst Jane had only worn the bracelet a few times, it was clearly very appreciated as a tangible thing to see/have, providing a material presence more ‘concrete’ than other memorial activities such as joining an online memorial site:

I'm always scared that I'm going to forget important events in my life. Therefore, the bracelet represented something real and concrete, so that every time I saw it or wear it, I remember what happened. The [online memorial meadow] is lovely, but I have to remember it's there, and make a conscious thought to go and look at it, which I will probably forget after a while.

Pertinent to cherub/angel imagery, particular features of material goods can resonate with dominant cultural conceptualisations and descriptions of new-born infants: as soft, cute and delicate (Layne 2000; see also Chapter 8).

contrast, items of jewellery tend to be more de- and re- attachable, though piercing jewellery is somewhat of an exception since these breach the flesh and alter skin surfaces also.

Some items of memorial jewellery also embodied some of these qualities, though not without practical problems around robustness, problematising the ‘hard’ enduring quality that Layne (2000) associates memorial jewellery with. Esther had bought a silver bracelet with an angel charm as her “remembrance thing, my token that it will never leave me”. She had worn the bracelet every day since but “it’s a fragile little thing... and I’ve broken it three times!” In addition, Esther valued a counter-part piece to the bracelet which she and her husband bought at the same time:

we’d talked about getting... a *something* [...] a... a... something we could have in the house that reminded us of what we’d lost, without it being obvious [...] so that a visitor to our home, a friend, anyone that came into our home wouldn’t necessarily know what it was or why it was there and we’d gone through ideas, things like a picture frame, an ornament, erm... in the end we actually settled on a jewellery stand because neither of us actually wear jewellery to bed so at night we take our wedding rings off and we put them on the jewellery stand. So we both wanted something that would be used every day, which it is, and it’s not obvious why it’s there.

The jewellery stand was a practical and highly meaningful counterpart to her memorial bracelet. The packaging of the bracelet was also significant: “it was the card that spoke to me more than the bracelet did” in emphasising ideas of hope, faith and belief. For Esther, the bracelet was chosen for evoking possibility regarding future children since she had been pregnant once, achieved through fertility treatment, and so hoped to become pregnant again to have a healthy baby, as well as being about “remembrance of the baby that we’d lost”. In a later interview, I asked Esther whether, after finishing her fertility treatment without a subsequent pregnancy, the meaning of the bracelet and the packaging message had changed:

the meaning changed to remind me that sometimes dreams change [...] so just because the original dream didn’t come true, it doesn’t mean that I don’t still have dreams and it doesn’t mean that THOSE dreams won’t come true. Just because that ONE [dream] wasn’t meant to be, doesn’t mean that dreams, new dreams, new hopes, new [...] won’t come true [...] and it reminds

me that even, even though what I originally wanted when the bracelet was bought for me... isn't going to happen... I've still got dreams, I've still got a future and they can still come true for me [for instance, in relation to adoption].

Hence, the memorial objects described served an important purpose through which Esther expressed not just a profound sense of loss, but also the intensity of her marital relationship and shared hopes for their revised familial futures.

Akin to my approach to skins in general, jewellery and clothes mediate “between the body and others and as such [are] both public and private” (Layne 2000 p338). As an item worn every day, and one which she described as aesthetically pretty but unusual for her taste in jewellery, Esther recalled a number of occasions when she had been asked about her bracelet. These encounters had sometimes opened opportunities to talk about her experience:

people often comment, especially if I've got short sleeves on, you know, 'pretty bracelet, isn't that lovely' and they see that it's the wings and most people do ask the significance of it and I'm not shy in any way, shape or form so I'm quite happy to tell people the significance of what it is for ME. And most people [say] 'oh, oh, very sorry to hear that happened.... okay' and the conversation rolls on but a few people will actually spend time, you know, talking about it.

There had been a number of times when Esther felt that the inquirer was not only inviting her to talk about her experiences but that “it's almost like they wanted me to open the conversation to allow THEM to talk about it”. As such, through a conversation about her bracelet, Esther discovered that an older female friend had experienced a late miscarriage a number of years previously:

Esther: she then shared with me HER experience and we had a really good cry on each other. But she, what she felt, what she said was that she'd wished she'd had something... PHYSICAL as a memory because at the time when she'd lost her baby, there hadn't been anything. So, she'd not had a funeral or a remembrance service, nothing, it had just happened and she'd gone back to work however many days or weeks later [...] she said if she'd of had it at

the time – it would have been wonderful, but she didn't need it now

Abi: hmm, so do you find it a good thing to have that bracelet to kind of prompt those erm I don't know if bonds is the right word but, you know, getting to know people in ways that maybe you hadn't before?

Esther: it's been useful, it's been useful, I wish I didn't NEED a physical something to start those conversations, I wish that people felt comfortable enough to start them without it but I would rather have it and be able to use it to talk to people than not have it at all.

Drawing on Riches and Dawson (1998 p136), as “more than records of memory”, memorial objects can function as “social props” for conversations about loss and/or bereavement. In the context of pregnancy loss, objects like memorial bracelets can foster connections between women on an informal, small scale basis, linking to Rosie's workplace toilet example (Chapter 4) and some participants' positive experiences of online support groups (Chapter 6).

Concluding Remarks

Skins and contours, as prominent sites regarding “the accumulations of a lifetime” (Winterson 1996 p89), are amenable to modifications and inscriptions of different kinds. In relation to pregnancy loss experiences, stretch-marks may denote rippling notions of ‘failure’ around pregnancy loss and flout normative feminine beauty ideals, but they can also convey sentiments of fond remembrance. Whilst stretch-marks were disliked and disguised by some, as with Carla's stretch-marks – for others, like Anne, these could be valued reminders as ‘evidence’ of past experiences of pregnancy. Sometimes visible skin-based marks or objects were actively sought and, as with Esther's bracelet, appreciated for the potential to strike up conversations about pregnancy losses. However, it is not possible to simply apply meanings to skins with the secure knowledge of how these will be ‘read’ by others and participants demonstrated that skin-based modifications and symbiotic material objects are subject to careful negotiation regarding visibility and legibility. Speaking of tattooing specifically, but to which I add other forms of marks on and alterations to the skin, Oksanen and Turtiainen's (2005 p122) comment that “although the picture on the skin has a relative permanence, the affects connected to it change

with the flow of life". Thus, the meanings about and engagements with skins marked or adorned in some way by pregnancy loss experiences are not static, but are dynamic and open to further spatial and temporal change.⁶³

I have argued that skin-based marks following pregnancy losses are not devoid of meaning nor attributed singular 'readings' and stretch-marks do not deterministically denote a sense of 'failure'. Rather, bodily exteriors and contours are subject to a range of possible interpretations, as shaped by numerous factors and contexts (Benthien 2002). As for Anne, whilst she disliked her stretch-marks itchy with PUPPP during her pregnancy, they became important embodied reminders of her cherished stillborn son in her past, ongoing and future life. Thus, in relation to pregnancy losses, skin-based marks can be particularly significant given the absence of material, embodied, living children or children-to-be (Bleyen 2010; Layne 2000). Examples discussed have supported a conceptualisation of skin surfaces and contours as potential repositories of memory and recipients of memorialisation. Within this, linking to discussions in Chapters 3 and 5, women's bodies are foregrounded as primary sites of loss and potentially another's dying and death, making the skin—as an interface between self and world (Benthien 2002)—a particularly suitable space at which dialogues are held between emotional states like grief and their expression with resultant memorialisations.

The themes of memory and memoriality have underpinned much of the discussions in this chapter on skins. Paralleling Rosenblatt *et al's* (1976) distinction between grief and mourning, I suggest that memory (like grief) can be understood to denote internally held *feelings* in response to an event whilst memoriality (like mourning) refers to the ways such feelings are *expressed* in terms of culturally defined acts physically performed. Hence, 'memory' and 'memoriality' are not discrete, radically different distinctions but relate to one another in porous ways. As such, some skin marks are acquired or 'reclaimed' as kinds of memorials embodied by the bereaved through acts, denoting agency and investing energy, concerned with meaning-making and narration. Thus,

⁶³ The longer term context is a topic with scope for further research to consider, for instance, how further physiological changes (including fading, stretching, discolouration) over extended periods of time may impact upon the meanings held about these pregnancy loss related skin-based modifications.

marks on/of the skin can be attributed the role of ‘memorialising’ or providing testament to something deemed significant, even if the existence of these was not initially ‘intended’ in such a way as with stretch-marks. Memoriality, in relation to the themes of materiality, absence, presence and continuing bonds theories, will now be further considered in Chapter 8.

Chapter 8: Pregnancy Loss Memorialisation

Introduction

Memorial practices testify to the significance of losses and, in the context of pregnancy loss, do so within a wider social environment which largely responds to such events with silence and/or denigration (Layne 1999). In contrast to other chapters in the thesis which have predominantly focused on the embodied experiences of ‘pre’- and ‘during’- pregnancy losses, Chapter 7 and this chapter attend more so to the post-occurrence ways that pregnancy losses are re-asserted, marked and narrated by those with such experiences in their ongoing lives. This chapter demonstrates, through several examples, that the themes of ‘absence’ and ‘presence’ are pivotal to thinking about memorialisation practices and objects which fundamentally attempt to convey meanings held about experiences of loss. Scholarship attending to ‘material culture’ in relation to memory and mourning has highlighted memorial objects as tangible entities with social meanings and uses (Hallam *et al* 1999; Garattini 2007; Gibson 2008; Doss 2010; Hockey *et al* 2010). For instance, Riches and Dawson (1998) find evidence of ‘continuing bonds’ grief theory in how bereaved parents (re)construct social identities for their deceased children with particular objects and conversations. This was also the case in my research on pregnancy loss although, as Diane commented (Chapter 7), the scope of existing material objects ‘belonging to’ or ‘reminding’ of pregnancy losses specifically can be relatively limited, hence her creation of one in the form of a memorial tattoo.

Memorialisation concerns relations between the bereaved and deceased, but also involves wider social contexts which, for pregnancy losses, include medical staff, family members, friends and online support group users (Chapters 3, 4 and 6). In particular, online and face-to-face pregnancy loss support groups play important roles in informing viewers/users about different kinds of memorial activities and events. This is in the sense that memorial practices are “private and personal but formed by the collective in narratives. The private rituals seem to need affirmation from others, a negotiation, and reconstruction forming the norms and values of ritualization” (Davidsson Bremborg 2012 p163). Support organisations, like MA and Sands in the UK, have campaigned for various forms of ‘memory-making’ in institutional settings such as hospitals with the collection and production of material artefacts in

anticipation of memorialisation. Following stillbirths and neonatal deaths, but potentially also used for other pregnancy losses, ‘memory’ boxes are used in hospitals – containing disposable cameras and hand-foot print kits, functioning as a place-object in which to store additional mementos such as ID bracelets, hats or blankets (Layne 2003a, 2004, 2006; Komaromy *et al* 2007). As mentioned (Chapter 5), there are ongoing debates as to which factors hinder or facilitate ‘healthy grief’, concerning aspects such as seeing deceased bodies and keeping mementos (Henley and Schott 2008; Rådestad *et al* 2009). However, when conversations and actions are carefully enacted by medical staff, it is possible to dispel notions that it is ‘abnormal’ to grieve, mourn and memorialise these events (McHaffie 2001; Davidson 2008; Rådestad *et al* 2009).

The structure of this final empirical chapter, relating to the concepts of ‘presence’ and ‘absence’ and grief theories of ‘continuing bonds’, will be as follows. I will outline the topics of memory, mourning and memorialisation in relation to pregnancy loss upon which I will elaborate four sets of examples from my research. The first will focus on examples of memorialisation concerning the material presence of embryonic, foetal and baby bodies in terms of official and informal graves. I will then discuss symbolic ornaments as kinds of physical substitutes for, or in addition to, the physicality of deceased embryo/foetal bodies. In the third set, I will consider ‘index’ examples: material objects involving ‘traces’ of previous but now absent bodily presences, such as ultrasonography scan images and, in relation to stillbirth and neonatal death, photographs. The fourth and final set of examples will focus on memorial practices which are deliberately ephemeral either as events, like releasing a Chinese lantern, or in terms of the ongoing pace of ‘everyday’ embodied life.

Remembering and Memorialising Pregnancy Losses

Absence can be partially invoked and ‘placed’ through materiality, leaving different kinds of presences and traces with subsequent effects (Meyer 2012). Material memorial practices and objects are thus recognised as significant responses to loss (Garattini 2007). In this chapter, I draw on the ways absence and presence “*hold together*” (Meyer 2012 p109 italics in original) to produce an account of (re)collected pregnancy loss memorialisation. Tonkin (2012 p6) comments that if a woman doesn’t have a child biologically but had planned to, “she engages in a process of accommodation to a life in which her

fantasy is not embodied, and that this process is often a lengthy one, fraught with ambivalence, and social and emotional complexities”.⁶⁴ Memories of the past as well as (shifting) anticipated futures are also crucial in my thinking about experiences of pregnancy loss. Finding affinity for understanding the experiences of my own participants, the language of ‘absence’ and ‘presence’ as utilised in Tonkin (2012) and recent geographical work on bereavement (see Maddrell 2013) will underpin my subsequent discussions.

Demonstrating the ways in which experiences pertain to not only individual persons but also socio-cultural collectives, Connerton (2011) emphasises that narrative-practices of ‘mourning’ and ‘legitimation’ are fundamentally intertwined. The testimonial genre, underpinned by the imperative that “[s]urvivors need to tell the truth about a historical catastrophe”, can entail varied “texts of mourning” such as those involving the media of cloth, paint, literature, cinema, photographs, songs and festivals (Connerton 2011 p22, p26). Connerton (2011) also argues that memories are retained and articulated through bodily actions including gestures, comportment and speech as well as deliberately in material forms such as memorial monuments. Mourning and memorialisation entail intentions to convey to others, and remind oneself, that the losses they represent are significant and worthy of acknowledgement. Individuals and potentially their social circles can be motivated by memories and emotions regarding pregnancy loss to ‘do’ something as a means of testifying to the significance of their experiences which they may or may not see as pertaining to the death of a person. In doing so, these endeavours can confront and counter the wider social attitude towards pregnancy loss perceived to be one of silence and/or denigration, resonating with Doka’s (2002) notion of ‘disenfranchised grief’.

As with Victorian mourning customs (Taylor 1983), orientations towards memorial practices are strongly related to and shaped by the wider context regarding what is deemed appropriate for the bereaved to do, say, wear and so on. In suggesting that memorial practices are influenced by the social, cultural,

⁶⁴ Relevant to my research, several ‘circumstantially childless’ women researched by Tonkin (2012) spoke about waning fertility so that their intentions and anticipation for (biological) children would shortly be or had been surpassed and some mentioned previous experiences in which pregnancy had been briefly embodied but had ended in termination or early miscarriage.

economic, historical, political and legal contexts in which they occur – this is not to imply that memories are somehow detached and independent of such influences. Consider the efforts to distinguish ‘healthy’ from ‘unhealthy’ grieving following bereavements generally and pregnancy loss specifically, as based on internal feelings as well as outward behaviours and impacts. Subsequently, ‘grief policing’ also concerns efforts to monitor and implement limitations on internal and external responses to bereavements in line with those considered by others, including psychology-trained experts as well as wider society, to be ‘acceptable’ and appropriate (Walter 1999; Small and Hockey 2001). Memories internally held *and* memoriality externally enacted are both subject to monitoring and regulation by oneself and others. Therefore, wider social attitudes, dialoguing with prescriptive notions of normality—including in line with reductionist approaches to grading and measuring grief as evidenced in a number of studies in the discipline of psychology (Small 2001)—can restrictively delineate what is deemed appropriate or not to ‘do’ during/following events of pregnancy loss.

Memories, with scope for pregnancy loss memorialisation, can be held about many different aspects of one’s experiences. Regardless of whether legally considered a death of a person in relation to gestational age and/or post-partum breathing, this can include memories pertaining to the construction/attribution of social identities during, and even prior to, pregnancy and which can continue after loss (Layne 1999; Hockey and Draper 2005). In capitalist societies, ‘mothering’ from pregnancy onwards often entails acquisition of material objects ‘for’ or ‘belonging to’ the forthcoming baby such as clothes, bottles, cribs and toys (Layne 1999; Taylor 2004b). Subsequently, Miller (2004) suggests, shopping plays an important part in pregnant women developing themselves as ‘mothers’ with the relational counterpart of ‘baby’, as energy is also transferred to constructing the baby’s identity such as through buying booties and sleepsuits. The expectation is that a living child will be born to grow and occupy the social identity that the parents and their social circle often construct for them in lieu, as well as use the material goods. This trajectory is disrupted in events of pregnancy loss – however, as Layne (1999, 2000, 2003a, 2004) highlights, material objects may still be utilised to confirm and further develop the existence of the ‘baby’. Thus, ‘real things’, as tangible, concrete items associated with- or owned ‘by’- the ‘baby’ can denote ‘realness’ of the pregnancy

loss (Layne 1999, 2000, 2003a, 2004) and, subsequently, grief felt and the validity of mourning and memorialising.

The materiality of mourning and memorialisation can be understood to highlight not only the ‘legitimacy’ of an experience, but also attest to willingness to retain recognition of it, resonating with grief theories of continuing bonds (Silverman and Klass 1996; Small 2001). Processes of constructing social identities exceed biological lives, occurring before birth and continuing after death (Hockey and Draper 2005), and thus entail relationships between the living and the unborn and/or deceased as often mediated by material objects. Continuing bonds theories in the context of pregnancy loss can emphasise the enduring ways in which identities are (re)constructed of the ‘baby’, as parents and/or a family unit (Murphy 2009, 2012a, 2012b) with recognition of these experiences retained beyond the time-setting of actual occurrence. Indeed, Kempson and Murdock (2010) show that those who never knew about their deceased sibling(s), including because they were born subsequently, can become ‘memory keepers’. Walter (1996) suggests a model of grief in which the bereaved construct a durable biography to enable integration of the memory of the dead into their ongoing lives. One primary way in which this is done is via conversations with others who knew the deceased (Walter 1996). However, in the context of pregnancy loss, the social circle able and/or willing to engage in practices of (re)creating the identities of such ‘children’ may be very limited and precarious. Wider social others, whom often had been encouraging and were themselves engaged in the social construction of the forthcoming-baby during a ‘healthy’ pregnancy, may then retract this investment and instead disapprove, trivialise or actively hinder mourning and memorialising efforts when pregnancy losses occur (Murphy 2012a).

Building on recognition that palimpsestic, multi-vocal memories reside in space with traces of the forgotten, geographical scholarship has highlighted a range of localities whereby *efforts to remember* (memorialise) take place and leave material deposits. Some ‘geographies of death and dying’ examples were mentioned in Chapter 5, such as spontaneous memorials, monuments and memorial benches. Bleyen (2010) and Woodthorpe (2012) argue that pregnancy losses memorialisation tends to be aesthetically-materially different, in terms of a playful tone and more extensive/prolific accumulations, to that found at adult

graves. As Woodthorpe (2012 p147) highlights, memorial gardens for babies and ‘nearly viable foetuses’ in the UK can seem like “colourful, ornate and youthful area[s]” to the visitor. Davidsson Bremborg (2012) notes some specific memorial practices around events like stillbirths such as blowing bubbles at grave sites in the Swedish context. In addition to the material objects left at memorial sites, whether these are the actual graves or collective cenotaph-style sites like memorial gardens, the physical layout of the space is significant. In Woodthorpe’s (2012) research with crematoria and cemetery managers, particular conceptualisation of baby gardens emerged as bounded communities akin to crèches, nurseries or playgrounds where the babies were ‘together’ in shared companionship. One cemetery manager anticipated bereaved parents to dislike a bounded baby garden located near a war memorial grave section; however, this location was embraced since the soldiers (graves) were seen as protecting the “vulnerable and defenceless [baby garden] residents” (Woodthorpe 2012 p148). Graves will be the first set of examples I now discuss.

Physical, Bodily Presence: Graves

Encountering embryonic/foetal bodies and placental materiality outside of the woman’s body featured prominently in Chapter 5; here, I further consider this topic in relation to mourning and memorial activity-spaces. That pregnancy losses over 24 weeks gestation are currently in the UK legally considered deaths and must be registered as such has implications for, for instance, funerary practices. Both Diane and Fiona suggested that early miscarriages are not widely socially recognised and that this links to a lack of material evidence left by, and indeed of, those ‘persons’ now deceased. Subsequently, some pregnancy losses are more likely than others to be offered, encouraged or regarded as appropriate for funerals in addition to other memorial practices by the hospital, for example, whilst others are not and indeed it may be largely considered improper to do so. Amongst research participants, attendance at official funerals was discussed by Siobhan (neonatal death of her nephew), Ben (stillbirth of his niece), Anne (stillbirth of her son), Isabel (late miscarriage at 20 weeks), and Tania (miscarriage at 14 weeks). In addition, Lara and Caroline spoke about informal burials in gardens or parks of their early miscarriages.

Coffins, as interfaces between the bodies of the bereaved and the deceased, can be evocative sights/sites since these materialise the loss and bring

home the physical reality as a powerful symbol of absence (McHaffie 2001; Valentine 2008). The emotional intensity was felt to be especially so for pregnancy loss funerals in which the visual aesthetics of the coffins are simultaneously small and yet 'too large' by virtue of existing at all and/or in relation to the size of the contained body. Ben, speaking of the funeral of his stillborn niece, described the sight of "a tiny little baby's coffin" as a "powerful thing" which had noticeable impacts upon not only the funeral attendees but also onlookers who encountered the funeral procession: "I just remember that everybody stopped in the street and just kind of bowed their heads down [...] they were very kind of affected by it". The sight of "a tiny white coffin" was also commented on by Anne who visited the funeral home with her husband to "see what the coffin looked like so it wasn't a massive shock". McHaffie (2001 p229) suggests that funeral directors have additional responsibilities in the context of baby deaths to help prepare the bereaved for these sights and that they might potentially offer "less exceptional and heartrendering [options], such as an ordinary wooden coffin". Finding it helpful in preparing her, "because to see a tiny coffin is a HUGE shock", Anne had passed on this advice to visit the funeral home to other online support group users (as mentioned in Chapter 6).

Some participants had not anticipated funerals being offered in relation to their pregnancy losses which, whilst denoting legitimacy of the bereavement, can also be tinged with ambivalence. Following her late miscarriage, Tania gave a noncommittal response to a nurse informing her "that the hospital has religious services for all the babies that have been lost [...] I'm not religious so [I] didn't want to attend but I just asked her to send me some information closer to the date". Several days later, the hospital called "to say they had arranged a funeral service for my baby as they thought that was what I wanted [...] it was booked and would still go ahead with or without me". Tania's husband was concerned about the impact attending might have on her, but she explained "I couldn't have my baby there in a coffin alone, no matter how many weeks it was I wasn't going to have a ceremony with no-one there". The experience of the funeral was fraught, although Tania and her husband "both felt much peace afterwards". She recalled watching "as they brought out a baby sized coffin which was horrendous, I knew my baby was tiny in there but the size of the coffin just made it so much worse". The visual sight of the coffin prompted divergent feelings: "my baby was only 14 weeks old [gestation] and I didn't feel

comfortable with a full funeral service” alongside recognition of the magnitude of loss entailing projected futures and the identity of the child-that-could-have-been:

it was so hard because it felt as though it was a much older baby inside that coffin [...] we couldn't help but think who that baby may have become, we were going to miss watching him (I felt it was a boy) grow up, whether he'd love football as much as his brother, whether he'd have the cheeky smile like his sister.

Thus, as for these participants, the specific aesthetic qualities of many pregnancy loss coffins were intensely emotionally triggering, in materially foregrounding ruptured linear expectations about the life of the forthcoming-baby with biological- absence, loss and/or death.

The offer of an official funeral also diverged with Isabel's expectations and she was “amazed” that the hospital arranged a funeral “seeing as he was considered to be a 'late miscarriage' [at 20 weeks] and not a still[-]birth”. She added that “[e]ven if he was a still[-]birth, I would not have expected a funeral” and “thought that was really nice of them to do that”. Isabel also spoke about the specific aesthetics of the funeral, including “a white flower wreath in the shape of a teddy bear”. White flowers, symbolising purity and innocence, were also present at the funeral described by Tania who “placed a white rose on the coffin”. After the funeral, Isabel and her sister relocated the teddy bear flower wreath to a relative's grave in a nearby churchyard. This grave then became a key proxy site visited in the absence of another fixed place, as her son's ashes were scattered at the crematorium some distance away: “[I] can, you know, go somewhere and go and talk to him. So normally if... if I'm thinking of him or something, I'll take flowers over to the relative's grave and sort of like talk to him there”.

Facilitated through the located, material bodily remains, the site of burials and ash-scattering can allow the bereaved to retain connections with the deceased (Francis *et al* 2001, 2005; Davies 1997; Voller 1991). In contrast to ashes, which “are one step removed from the [coherence/likeness of the] body”, burial sites are particularly important in facilitating or permitting ‘connections’ with the deceased as “trigger[s] for memory” and a “basis for a continuing

relationship perpetuated through visiting the grave and often engaging in conversation with the dead” (Davies 1997 p175). In addition to the issue of proximity to her home, this factor may also underpin Isabel’s preferred location, the burial site of another relative near by, for retaining connection to her son.

Connections *between* the two sites for Isabel, from the funeral at the crematorium to the pre-existing grave in a nearby cemetery, were facilitated by the movement and materiality of the teddy bear flower wreath. As a ‘vehicle’, the wreath linked the locations so that the proxy grave supported ongoing connections between Isabel and her deceased baby, as exercised when she visits to think about and talk to him. ‘Proxy’ sites, where their own pregnancy losses were not/yet physically located, were also used by some participants for remembrance and memorialisation. For instance, Penny sometimes visited a baby garden at a local crematorium and hoped to eventually have the ashes from her miscarriage transferred to this site. She described it as a “very beautiful” place, allowing “a bit of closure” and “a chance to say goodbye”, although she anticipated that the relocation of the ashes from her miscarriage would mean that the distress would “all come back and I will struggle again”. Isabel mentioned another example of connections *between* sited experiences associated with different deceased persons, highlighting that pregnancy loss funerals can trigger and ricochet with other experiences of bereavement:

I just wanted it [the funeral] to just be quiet and so just REALLY for me and [my husband] to go, erm... but [he] didn’t want to go, erm I think one reason was because of HIS family past and because his, his mother passed away when he was a teenager and so I think possibly it was a link to that. He didn’t want to [go] because the funeral was at the same place so I don’t think he wanted to be reminded of that.

With the exception of her sister, Isabel decided not to tell other family members about, or invite them to, the funeral as she was acutely aware of the scope for ‘social policing’ of her grief, heightened especially by longstanding family politics with her mother. She explained: “I didn’t really want a big fuss and, you know, everyone to be crying and looking at me and sort of like judging me, the way I was behaving and stuff like that”. When I asked if the prospect of her behaviour being assessed at the funeral related to the specific circumstances of

pregnancy loss, Isabel responded: “yeah, I think, YEAH, because if sort of like you knew somebody then you’d be able to talk about them but... it’s a different situation isn’t it, for a baby you’ve not even sort of had, you know, has LIVED”. In this way, pregnancy losses can entail additional tensions and pressures regarding ‘grief policing’ (Walter 1999; Small and Hockey 2001).

Such sentiments were also echoed by Ben about the funeral for his stillborn niece. Regarding a notebook which had been passed around to funeral attendees, he explained how his sister, the mother of the stillborn baby, had:

Ben: really wanted to document the time, the life of the child, even though the child wasn’t, she viewed it as being alive – as if it had lived and even if it had only lived in her, her womb, but it still lived and she wanted to document this very short life as detailed as she could, erm

Abi: how did you feel about participating in that? Like, did you write in the notebook as well?

Ben: I wrote in it but I really struggled to write something and I thought it was a really good idea at the time and I understood the reasons behind it but I remember just thinking what can I write to [a] person I didn’t know.

This recollection foregrounds the additional difficulties faced for constructing a ‘durable biography’ of the deceased (Walter 1996), given lacking/limited shared memories. Similar to Isabel’s husband’s previous experience of bereavement underlying his decision not to attend the funeral, Ben also implied that multiple experiences of bereavement can connect with one another. The funeral of his stillborn niece had been the first funeral Ben attended “of a young person rather than [...] very very old people in the family who’d passed on”. Subsequently, it was “REALLY different, I mean REALLY different from any other funerals, there was so much more anguish”. Since then, Ben had attended an additional funeral for his father which was coincidentally on the anniversary of the funeral for his stillborn niece. Additionally, the two graves are located side-by-side in the cemetery meaning that when Ben visits his father’s grave primarily, he also visits and engages with that of his niece. These visits then become part of a wider conversation between Ben and other members of his family:

[at the graves, I say] hello to her and treat her as if she was some kind of {laughs} like distant family relative and there's just always a little small talk [with other family members afterwards] going "yeah I saw [niece], she's fine, her grave is looking well", because we always take good care of it and make sure that it's erm and all the plants and everything are well tended to.

Reiterating that there is often specific aesthetic qualities of pregnancy/baby loss graves markedly different to those traditionally of adult graves (Bleyen 2010; Woodthorpe 2012), Ben remarked at the contrast between these two graves:

my dad's grave still doesn't even have a tomb stone on it {laughs} two years after his death 'cos we can't decide what to put on it so we just haven't done anything, it's quite funny, {laughs} it looks like an abandoned piece of grass and then yeah [my niece's] grave is always PRISTINE with so many decorations.

'Informal' burials were undertaken by some participants regarding their early pregnancy losses which neither required nor were permitted official registration of death. Resonating with Murphy and Philpin's (2010) observations about language uncertainty, Lara explained how, after an early miscarriage, she and her partner "buried it beneath a tree that I could see from my window so we can be close". Lara's hesitation, saying "I don't know if I'm supposed to have buried it in the place that I did", could pertain to issues of legality but also social propriety. The site chosen evokes connotations with 'nature', a theme which frequently features in pregnancy loss narratives (Layne 1999); indeed, gardens and parks were also commented on by some of my other participants. Layne (1999 p269) suggests the popularity of 'natural' settings and "garden memorabilia" pertains to the ways that such imagery "normalizes the child's death". After a series of traumatic hospital encounters, Caroline described how she stayed at home whilst miscarrying a fourth time, recalling her assertive sentiments: "I'm going to deal with it as I wanna deal with it and I will bury whatever comes out in my garden, and I don't care about what they think or say". As with visiting formal graves, the chosen burial site for the remains, under a pre-existing cherry tree, provided a space at which Caroline could maintain relationships with all four of her miscarried 'children':

I just thought it was nice because it was quite a blossom-y tree and I liked it, I liked the tree and I like the garden 'cos it's peaceful and yeah, the baby's still [buried] there [...] [I] probably look like a mad woman {laughs} but I go [outside sometimes] for a little natter.

Through the memorialising actions of visiting (official, unofficial) graves—as well as actions such as talking to the deceased, leaving flowers, tending the vegetation and cleaning a memorial stone/plaque—"the cemetery enables the living to remember the dead and to construct meaning through social action and the materiality of the grave" (Francis *et al* 2005 p19). Thus, graves can be physical locations at which the social presences of pregnancy loss 'babies', which are also absences of embodied persons, are acknowledged and incorporated into the lives of those participating in such memorialisation activities.

As suggested so far, whilst the locations at which the specific material bodies of pregnancy losses are interred can provide focal points, there is also flexibility and more fluidity regarding the spaces which can permit such emotional and physical connections. This includes the example described by Isabel in which the primary site visited was transferred from the crematorium to another relative's grave. Another example was given by Caroline, who demonstrated that her relationships and engagements with the subjects of her pregnancy losses did not necessitate being near the cherry tree. Characterising herself ambiguously in relation to religion, Caroline nonetheless suggested her receptiveness and perhaps hope as to the possibility of an afterlife:

sometimes I lie in bed at night and natter because you don't know what's beyond do you, just have a little natter, you know, 'this is what's going on and so on', 10 years on and I still talk to them, why not, it's not hurting anybody.

With heaven constituting a particular spatial reference (Grainger 1998), Caroline's practice of talking to her deceased 'babies' wherever she is suggests a belief in omnipresent afterlife as able to traverse space-time differences (between where Caroline is and where the deceased 'are'). Whilst she has one informal burial site, being at the location of the physical bodily remains of the deceased is not necessary to her continuing bonds. Memorialisation can thus be

transferred elsewhere and, Caroline implied, potentially everywhere and anywhere. This is particularly salient for those without interment sites for their pregnancy losses and, as I will now discuss, who utilise other objects with symbolic currency in the absence of, or in addition to, such bodily materiality.

Symbolic Absence-Presence Through Material Objects

Rendering the absence of a loss/deceased entity present in the form of objects, memorial ‘things’ “resonate with [contemporary] beliefs in the symbolic and emotional power of material culture” (Doss 2010 p71). As noted, this is a key observation in the literature on death, loss and material culture (Riches and Dawson 1998; Hockey *et al* 2001, 2010; Maddrell and Sidaway 2001, Doss 2002, 2010; Gibson 2008) and on pregnancy losses specifically (Bleyen 2010; Woodthorpe 2012). As Bleyen (2010 p17) notes, the use and acquisition of ‘things’ to evoke memory and enact memorialisation pertains to the ways that “the invisibility of someone who has died—perhaps most tellingly when they had no previous embodiment lodged in the memories of their survivors—can work to powerfully evoke their presence”. Engagements between the bereaved with such objects are simultaneously physical and emotional, potentially resonating in ways with some kinds of sensuous experiences entailed in ‘parenting’ living children. Regarding the material culture surrounding pregnancy loss, tying into the wider interlinks between mothering and capitalism (Taylor 2004b), Layne (1999, 2000, 2003a, 2004) highlights a range of gift-giving practices and scenarios in which objects are used to represent pregnancy losses. Some aspects of these will now be discussed in relation to Diane, who had a cabinet containing various items memorialising her pregnancy losses as well as the remains of one eight week embryo in a test-tube container.

Although not the only research participant who owned memorial ‘things’, Diane seemed to have the most prolific and extensive collection pertaining to seven miscarriages. The collection was incredibly important to Diane yet she feared being negatively judged about particular components: “I think only the lady from the mc [miscarriage] support group knows about the loss I have [in the test-tube] at home so I have never really had a reaction from anyone, but I have a feeling people who don’t understand would think it was odd”. Given her anxieties, I was privileged that Diane was willing to talk with me, commenting “I don’t share [this] with any one in case they think I’m odd but I will share with

you”, and offered to “send you a photo if you wish[,] I wouldn’t mind at all”. Though two of her previous miscarriages had been surgically managed, Diane was asked only the third time about disposal preferences on a consent form – indicating that taking the embryo remains home was an option. With written recognition that this was possible, and the implication that others had done so, Diane felt legitimised in requesting to take home the embryo remains. She had originally planned to bury the remains in part of her garden dedicated as a memorial with plants and ornaments to her miscarriages. However, saying “[I] couldn[’]t bring myself to do it”, Diane was ultimately glad that she had not done so as she had since moved home: “I cried when packing up all the things out of my old garden as that was my special place and when I was feeling really sad I used to sit on the wall looking at all the things I had done for my babies”.

Diane had created a memorial collection in a cabinet with the accumulation over time of, amongst others, angel/cherub ornaments and teddy bears. These can be understood as “objects which stand in for the child who has died [... and] serve a figurative purpose in making present the absent baby” (Bleyen 2010 p17). In addition, such surrounding items in the cabinet were considered by Diane to create a suitable space for the embryo remains, nestled within a “fancy pot” ‘held’ by a small teddy bear toy. Angel imagery is particularly salient in representing miscarriages (Layne 2000, 2003a; Keane 2009) and, additionally, “[s]tuffed animals, teddy bears in particular, intimate lost innocence” (Doss 2010 p71) as with Isabel’s flower wreath, Anne’s sister’s teddy in baby clothes and Woodthorpe’s (2012) example in which one teddy bear left in the hedge of a baby memorial garden can soon proliferate into many as others visitors/users add their own. Teddies are a common gift given to forthcoming pregnancies in which a living baby is anticipated, but, as in this case, can also be given ‘in memory’ following pregnancy losses. For Diane, it seemed that the nearby proximity of the placed teddy bears was a reversal of touching and holding between ‘baby’ and ‘teddy’. The disrupted usual expectations of active touch *by* the baby/child were further emphasised by the juxtaposed sizes, with the teddy being much larger than the very “small” ‘baby’:

the teddy ornaments are there for my babies as they were not here
to be able to have their first teddy when [they were] born [...] the

teddy in the box with my loss is holding the test tube, so instead of my baby holding its first teddy – the teddy is holding the baby[.]

The material presence of Diane's collection of teddy bears symbolically 'owned' by the "lost babies" can be understood to involve the kinds of gift-giving practices identified by Layne (1999, 2000, 2003a, 2004). Such material objects and associated practices of 'gifting', in multiple relations/directions, render the deceased baby an absence-presence in the lives of the living (Layne 1999, 2000, 2003a). For example, following pregnancy loss, gifts can be given in the name/on behalf of deceased babies, such as with donations to charitable organisations offering pregnancy loss support and furthering research (Layne 1999, 2003a). The teddies in Diane's cabinet, 'for' the miscarried babies and 'holding' one miscarried embryo, can be understood as examples of gifts given to the deceased babies which simultaneously constitute memorial objects. The teddies are gifts 'to' the miscarried children ('given' after the miscarriages have occurred) but they are also kinds of memorial objects which Diane has gifted to herself (perhaps, in sentiment, 'from' the babies) to keep, display and, indeed, care for.

As Murphy (2009, 2012a, 2012b) shows, in recognising that social parenting occurs during pregnancy simultaneously with biological parenting, it becomes possible to consider the activities of 'caring' and 'attending to' (touching, looking at, smelling) memorial objects as forms of negotiating and maintaining parental identity in addition to the post-life social identities of the babies. Murphy (2009) argues for recognition of the ways in which 'bereaved parents' continue to actively 'parent' their stillborn children through various social activities, including with the example of cleaning the child's grave instead of their bedroom. Families and/or individuals can continue to (re)construct particular relationships with the deceased child, restoring and supporting one's identity as a mother/parent (Murphy 2009).⁶⁵ Thus, Diane can be understood as having collected various things 'for' her miscarried children – organising, cleaning and preserving these in the cabinet as well as with other objects dispersed throughout her home. Layne (1999, 2000, 2003a) and Murphy (2009) foreground the physicality and tangibility of material objects involved in

⁶⁵ As such, I suggest that the aforementioned example of Anne's sister's plans to dress a teddy in a baby grow previously bought constitutes an example of enacting the identity of 'being an aunt' via objects which, given the circumstances of stillbirth, are also memorials.

such practices of ‘active parenting’ with (relational) identity constitution. ‘Baby things’ as memorial objects embody “shared qualities of babyhood which are so culturally valued” (Layne 2000 p339, 2003a), evident in the ‘softness’ and ‘cuteness’ of Diane’s teddies. In the same ways that one can interact with living, moving and growing babies, ‘baby thing’ memorial objects can enable physical engagements like intentional touching and looking. Layne (2000 p324) describes how such objects permit this by being:

sentiently apprehended in the same ways that living children are, but that dead children (once they have been buried or disposed of) no longer can be. They can be touched, held, caressed, hugged, and gazed upon. [...] Like children, they can also be cleaned, protected, and displayed for the admiration of others.

This denotes an *active* notion of loss, as tasks of parenting are missed (Murphy 2012a), and of memorialisation whereby objects are cared for (Garattini 2007).

Diane recognised that the presence of the memorial items inside her home and in the garden could become such staple and everyday components that they slip from awareness. This is not to say that they are simply erased; they are present and seen but in a way that is normalised as part of her life and home space, much like living children. Diane explained that the objects in her cabinet, foregrounding meanings of absence, are presences “to remember my babies” but that “to be honest I forget it [the embryo] is there”. Thus, the objects and bodily remains are ‘constant reminders’ (Murphy 2009) but in a familiar, partially noticed way. This likely pertains to elapsed time, with the vast majority of Diane’s miscarriages occurring over a decade ago, as well as other life pressures such as a demanding job and attending to her living family/children. Another aspect, I suggest, is that the memorial objects are no longer simply ‘in’ her home but are physically and emotionally central to the constitution ‘of’ her home as such. The objects are an “assertion” of her feelings on the miscarriage losses (Layne 1999 p268), powerfully anchoring continued bonds to (sub-locations of) her home and thus firmly incorporated into Diane’s life so that constant recall is not necessary. That is, memorial objects can be memory prosthesis: materially present, allowing one not to have to continually cognitively recall the past, thus permitting a kind of ‘background’ remembering. However, this may only be momentarily, especially given that *recognition* of

having ‘disremembered’ can have the paradoxical “effect of drawing attention to them, and so causing them to be remembered” (Connerton 2011 p41). This, as I will shortly discuss, can also be the case for ‘index’ memorial objects.

Traces of Physical Absence-Presence: Scan Images and Photography

Photographs, hand-foot prints and ultrasonography images—as indexical items (Layne 2003a; Keane 2009)—refer to the biological bodily existence of embryos, fetuses and babies and are objects crucial to practices of contemporary social identity construction both pre-birth and post-death (Hockey and Draper 2005). Ultrasonography images, usually taken whilst pregnancies were ongoing and considered viable, as well as photographs and hand-foot prints, which can be taken following birth before and/or after death, are kinds of material objects which embody a notion of directness or proximity to the now-lost baby/pregnancy (Layne 2000, 2003a). The status of these *as objects*, however, can go unnoticed when focus is on the images depicted in/on them, thus potentially obscuring various social practices (Edwards 2001, 2005; Batchen 2004; Edwards and Hart 2004; Gibson 2008; Rose 2010). The production of image-objects like ultrasonography scans, photographs and foot-hand prints intimately depend on particular technologies—such as ultrasound machinery, paper-ink and cameras—embedded within networks of relations and environments, involving ultrasonography technicians, medical rooms, nurses, darkrooms and photographic process workers. These collections and connections underpinning production are often, however, backgrounded or overlooked when such image-objects are understood as having directly ‘touched’ the foetus/baby and produced the object as a material ‘fact’ of their previous presence. When image-objects depicting the subjects of loss are utilised for their abilities for reminding, engagements with them such as displaying and ‘merely’ looking can be understood to constitute memorial acts (Batchen 2004).

Worden (1993) suggests that seeing the deceased body can help the bereaved confirm and accept the death, especially if this occurrence is unexpected and sudden as, I add, is often the case with pregnancy loss. With precedents in Victorian practices of post-mortem photography regarding child and adult subjects, Riechers (2008) notes that contemporary stillbirth photographs may also be used in this way. Such photographs have the benefit of being amenable to re-viewing, storage, reproduction of additional copies,

dispersed viewing and display as well as to being digitally re-touched (Mander and Marshall 2003; Sassoon 2004; Godel 2007; Gersham 2009; Keane 2009; Davidsson Bremborg 2012). Photographs, as material presences, invoke the absence of the persons/entities depicted (Batchen 2004; Prosser 2005; Gibson 2008) and foreground the impossibility to retrieve memories in entirety (Legg 2007), including aspects of smell and touch (Pattison 2007). Ultrasound images as well as ink prints may be used to this purpose in the absence of photographs pre- or post- death; all of these may subsequently be used in pregnancy loss memorialisation. As with 'baby things' (Layne 2000, 2003a), these image-objects can be viewed, touched, kissed, caressed, squeezed, displayed and shared as well as printed onto other objects such as coasters (Rose 2010).

Subsequently, such image-objects can be present in, or brought into, a range of 'everyday' spaces and practices. For instance, Siobhan described ultrasonography and photographic images of her nephew, who died 45 minutes after birth, placed in: the homes of her family members; displayed in frames and on the fridge door as well as kept in a memory box; carried in Siobhan's purse; and further circulated with an obituary notice in a local newspaper. The emphasis on the physical body of the deceased in such image-objects, albeit mediated and produced through forms of technology, highlights the strong links with "[p]re- and post-life identities [...] At either end of the life course, therefore, the body-to-be and the body-that-was, in their parallel invisibility, constitute powerful focuses for representation and identification" (Hockey and Draper 2005 p48). In particular, such image-objects can help "recover the body from the sequestration of hospital management and the obscurity of the womb and the tomb" (Hockey and Draper 2005 p48). Siobhan commented on the enjoyment of thinking about her nephew as facilitated through photographs: "it's quite nice to see the picture of him where he looks quite content or erm... whenever, because the pictures I have of him are when he was alive, so it's quite nice to have him, it's quite nice to have a picture of me and him as well". She knew at the time that the photographs would be the only ones of her nephew and subsequently would be important image-objects to aid her memory of him in the near future. Explicit about her preference of these, regardless of image quality, over those taken after he had died – the photographs of her nephew alive were key to Siobhan's recovery of some happiness, that he had been a living presence in her own life, amidst her sadness and sense of injustice.

However, it was not always possible through the acquisition and use of such image-objects to ‘reclaim’ the person-body from the experiences of hospital encounters and the incomprehensibility of (simultaneous) pre-birth and post-death. For example, in relation to her stillbirth, Anne described knowing and articulating to medical staff that “we definitely don’t want any photographs, definitely, definitely, and they did ask us a few times whether we did but we just both instinctively decided, KNEW, we didn’t really want them”. One reason pertained to anxieties “because we knew he’d already died before he was born so... sort of... nobody can tell you what you’re going to see, you know, and I think we were both just really worried”. Anne’s experience of stillbirth heartbreakingly contrasted to the anticipated live birth:

I haven’t actually talked to my husband about this – but I’m sure my husband had imagined the birth as well as I had, you know, you imagine giving birth to a baby and you talk when you’re doing your birth plan with your midwife like about skin-to-skin contact and seeing your baby straight away and {teary} all those kinds of things and, and, things being so different to how you imagine they’re going to be, it just really throws you, you know, we were just distraught.

A comment from one of the attending midwives “made things significantly worse for us”, dramatically confounding Anne’s apprehensions about seeing her son. She recounted how, following a short rest after the birth, in the morning:

[a midwife] said “oh do you want to see him?” and we said “yeah we do” and she said “well I think you’re better off seeing him whilst he’s still fresh”... which is a really horrible thing to say and conjured up all kinds of images about... oh, all sorts of stuff really because it made him sound like a bit of meat and that he was going to go off and that’s troubled us significantly since and we’ve actually {sigh} fed that back to the hospital that it was a completely horrible thing for her to say.

Whilst there are a range of factors—such as time elapsed—which can impact bereaved parents’ experiences of holding a stillborn baby, potentially making the difference between a tender or frightening encounter (Rådestad *et al* 2009),

this comment was clearly inopportune and it subsequently amplified distress. Although Anne ultimately did see her son on several occasions during the hospital stay, she chose not to have photographs taken. She explained how the shock of the experience meant that “the things you’d normally do after a birth if the baby was alive, you know, hold them and feed them and take pictures of them, none of those *really* felt like options to us. So erm we just couldn’t do it basically”. She commented that she has since had a few occasions of “panic” about not having any photographs:

because I can’t *really* remember what he looked like, I sort of can and sort of cant, erm... but I’m glad we didn’t, we both instinctively knew we didn’t want a picture [...] because he’d already died, you could tell he was dead, looking at him properly, you could tell he was dead, I know people talk about born sleeping but he didn’t look like he was sleeping, he looked dead and the LAST thing I would really want sitting about is pictures of him dead basically {teary}

Her grief and shock, further exacerbated with the midwife’s insensitive comment, meant that Anne and her husband chose not to have photographs taken and instead preferred to have the ultrasonography scan images on display at home. She explained that “[w]e want to remember him during the pregnancy when he was moving about a lot and you know, the, erm, that’s why we still have the scan pictures up and stuff, we want to remember him when he was alive”.

Such visible displays in one’s home following pregnancy loss can be understood to “make an assertion regarding the value of that [baby’s] existence, that it was deserving of recognition” (Layne 2003a p130). Anne explained how framed foot prints and a scan image featured prominently as a presence in their home and yet these were now something she (and others) had become accustomed to seeing, normalised “within the sphere of everyday family life” (Layne 1999 p266). She recounted: “when we first put the footprints up, one or two people commented on it, but now people are used to seeing them and the scan pictures, so they just don’t make any comment about it really”. As discussed in relation to Diane, such familiarity is not the same as being ‘forgotten’ and, linking to Connerton (2011), recognition of having normalised these presences can, paradoxically, demand attention and reinvigorate

remembering. Indeed, during our second telephone interview, the ongoing and familiar presence of the ultrasound image and foot prints as part ‘of’, not merely ‘in’, Anne’s home also became apparent as presences in our conversation:

[the scan is] on the living room mantle-piece, in fact I’m looking at it right now {laughs} because I’m in my living room, there’s a picture, there’s one of his 20 week scan pictures – the one we liked the best and there’s also... a bit further along, to one side, is his foot prints as well in a frame so we still have those out.

Pregnancy loss image-objects can invoke a range of different emotional responses; for example, whilst (some) photographs are fondly appreciated, they can also prompt controversy and responses of disapproval (Layne 2003a). As mentioned, both Anne and Siobhan highlighted their preferences of image-objects which “normalize the baby’s life” (Layne 1999 p269) and expressed varying degrees of dislike and/or discomfort towards those which depict the baby when deceased. For instance, Siobhan kept in her purse a photograph of her nephew taken whilst he was alive, which she had shown to some friends:

whenever I did show them photos, because they asked to see photos like, they recognised him as a baby – they didn’t think of him as just somebody, or as just as if he’d died before he’d lived really and they wanted to see the pictures of him and they thought that he looked like a little boy and they thought he was nice.

In this way, the photograph served to ‘equalise’ by conveying and socially-sharing, with responses of validation, an orientation that recognised Siobhan’s nephew as a much loved person and, to cite the title of Layne’s (2000) paper, a ‘real’ baby. Ben, speaking about photographs of his stillborn niece, also echoed this notion:

my dad always used to put pictures of his grandchildren up erm and I think for a brief time he had the photos like propped up on his desk [...] But erm {laughs} with time you get new grandchildren and then all the photos change and he took down the babies that have grown up and then replaced it with new babies so kind of it [a photograph of my stillborn niece] really had

its share in our house in the same way that all the other photos of the grandchildren have had.

Favoured image-objects can therefore feature prominently in significant lived spaces for numerous family members affected by pregnancy losses and, as with the photograph of her nephew retained in Siobhan's purse, can be kept close to one's body as a valued possession available to access anytime and anywhere.

However, echoing Anne's comments, participants sometimes expressed varying degrees of discomfort with regards to (some) photographs. For instance, Ben reiterated on a number of occasions that the photographs of his niece were not "morbid" but, as he did so, retained a trace of ambivalence perhaps pertaining to anticipated negative responses/expectations of others:

during the funeral I remember there were cards and a photobook – it had photos of the corpse, of the body and erm like photos of my sister and her, the father, with the, like with, like, holding the... the body. NOT in a kind of creepy kind of family photo way but just {laughs} photos of them with the child.

Siobhan felt especially uncomfortable, finding it "odd", that a post-death photograph of her nephew featured in an obituary notice that her sister placed in the newspaper: "that kind of put me off more". She had assumed an etiquette of baby death obituaries to exclude such images and she conveyed the ways she felt that the photographs taken once deceased were not able to capture the memories she prefers to recall about him, further rendering experiential details such as the kinaesthetics and sounds of his 'living' absent. Siobhan explained:

he looked differently when he was dead and that's what's quite shocking for me because it was only me and my sister that got to see him when he was alive. By the time my family had come up to see him, and because it was in the middle of the night, they [have] only seen him dead and he'd changed because when he was alive he looked, he looked, not that he doesn't look like a real baby but he looked like a normal baby like... largely, without, obviously if you don't count the difficulties he had with his brain which they covered with a hat. He looked like and really acted like a real baby and moved and made noises like a real baby but they never got to

see that. So I'd kind of prefer that they have the pictures of him when he was alive than when he was dead really.

The social context of viewing is particularly important here. It was not 'seeing', or having others see, the deceased body of her nephew *per se* which Siobhan objected to. Indeed, recognising the unusual circumstances, the open wake had been valuable for, as I suggested, 'equalising' her nephew as 'real' and loved:

we were advised, actually, by the undertaker not to have an open coffin because he was a baby and he was so small and because of his injuries [birth defects] as well. Erm... but my sister felt very strongly that she wanted people to see that he wasn't, that he was a NORMAL baby, whatever normal is, but that he was a baby regardless of his troubles. Some of the people who came to pay their respects didn't go to see the baby because, they, maybe they were frightened, or they didn't want to see... what they thought was going to be a gruesome sight. But whoever did see the baby said they were glad to see it, largely, because he was a little baby and he did live.

It seemed, therefore, that the issue which caused discomfort regarding the photographs was the fact that there were images of her nephew whilst alive which Siobhan deemed preferable, especially given that the newspaper obituary permits unfettered viewing by those who did not know the family or necessarily understand the context of their bereavement.

The topic of unintended or uninvited viewing also emerged in the narratives of other participants, pertaining to recognition of the tensions and possible upsetting scenarios that keeping the image-objects may lead to. Conveying the inadequacy of language for making sense of her experience of a late termination following a positive prenatal diagnosis, Gemma explained that "[w]e had pictures and footprints taken at the 'birth' (There isn't a name for it? 'Delivery' would be more suitable)". As such, her experiences involved "two intertwined presses [...] of making the decision to end an abnormal pregnancy while negotiating a relationship with the unborn child" (Bryar 1997 p566; Hunt *et al* 2009) with memento items. Gemma had never had these image-objects on display in her home and she kept them, with "just a few other little bits", in a

box. Gemma explained, however, that her “partner thin[k]s it is time to let them go, he is worried that the kids might find them, he thinks it is too sad, but I want to keep them for now”. Subsequently, the life-course of such memento and memorial objects can be shaped unknowingly by persons whose possible inadvertent viewing and comprehension of these would be undesirable. This concern prompted reflection within an interview as to whether Gemma anticipates telling her children about her experiences of pregnancy loss:

that’s a tricky one, I think when they’re much, much older, yeah and I think partly, you know... also for practical reasons too because it [spina bifida] is something that runs in [families], people can be more prone to [...] yeah, it might happen to them... but I don’t think it’s something that I’d want to talk to them about until they were like adults, like 16 or something.

Thus, the pre-empted, future use and retention of such image-objects can concern not only the preferences of the woman who physiologically experienced pregnancy losses and, as for Gemma, her partner – but also involves consideration about how these items may upset and inform familial/social others such as one’s living children (Forhan 2010), including those subsequent whose siblings were never known (Kempson and Murdock 2010). It also raises the issue of ‘legibility’ regarding whether memorial objects or practices are comprehended by others and/or explained in these terms. This, along with the theme of temporality, links to the next and final set of examples: ‘ephemeral’ memorialisations, appreciated precisely for their capacity to invoke ‘briefness’.

Ephemerality and Invoked Absence-Presence

Some forms of memorialisation seem particularly apt for pregnancy losses owing to their particular ephemeral qualities, able to capture and represent precarious and fleeting traces of ‘presence’ in the face of enduring embodied absence. One example mentioned earlier is bubble-blowing at the graves of stillborn babies (Davidsson Bremborg 2012) which, I suggest, may be chosen precisely because this activity entails acknowledging the fragility and temporary existence of each iridescent sphere as a presence prior to popping or being blown away. Such qualities of bubbles can therefore be understood to symbolically echo the ways in which the ‘babies’ of pregnancy loss are brief and

elusive presences followed by forms of persistent absence in the lives of the bereaved. Thus, as Doss (2010) discusses in relation to temporary memorials composed of flowers and letters amongst other materials, some things are chosen and utilised precisely because they are transient or impermanent. Of course, and as we have seen, this is not the case for all participants and the prospect of relatively short-lived memorial goods could evoke additional upset. Speaking about choosing a water feature to function as a memorial, Marie explained: “I wanted something for the garden and the most obvious would be a bush or a plant or something like that but I’m not exactly green fingered and I think if I’d bought a plant and it died, I think I’d be devastated”.

Certain kinds of memorial practices which some participants had engaged in can be understood as deliberately rejecting the kind of longer-term permanence evoked by stone grave markers or other enduring ‘hard’ objects. This resonates with comments about fabric-quilt memorials by Connerton (2011 p14-15) in relation to the different materialities of memorial objects/practices:

[w]hen a memorial is made of stone or bronze or steel, the rhetoric of the material implicitly claims that the memory of the dead recorded there will last forever. Cloth carries no such illusions of enduring witness. It is fragile, it fades and frays, it needs mending. It remembers the dead by sewing together mere fragments of their lives.

Material durability can be significant in conveying particular meanings and tenets of pregnancy losses experiences. For example, Holly described how she and her husband released a Chinese lantern on the beach whilst on a break away following her miscarriage. Though the holiday was booked in advance, it provided an opportunity to physically and psychologically recover:

what we decided to do was to release a Chinese lantern thing on the beach because we wanted to do something [...] and on the last night we decided that we’d have a picnic on the beach and we’d light the Chinese lantern. Erm, and the weather was amazing and it was really lovely but I spent the three days dreading that, dreading the idea of that, and I couldn’t sleep or anything, I was just like really worried about it, but I thought, you know, we gotta

do it - partly because [husband] really needed it, erm and I think he was right in that we needed something just to say 'this has happened'.

The act of 'releasing' the Chinese lantern was not irrelevant nor a hindrance to the communication of Holly and her husband's emotions and meanings about their pregnancy loss but rather, I suggest, crucial to the expression of these. Holly described how "it was getting really cold and it was pitch black by this point {laughs} and it was like come on, we've got to do it [...] it was really hard but I'm so glad we did it".

The notable strand of grief research from the 1990s onwards, collated under the label of 'continuing bonds', can be considered resistant, or at least reluctant, to engage in the modernist downplaying of interdependency and a drive towards model building (Silverman and Klass 1996; Silverman and Nickman 1996; Stroebe *et al* 1996; Small 2001). This ethos stems from an awareness of the risks emergent from imposing prescriptive judgements as to what constitutes 'abnormal' or 'pathological' grief (Rosenblatt 1996; Silverman and Nickman 1996; Walter 1996) alongside an appreciation that different ways of thinking about death, grief and mourning exist in other cultures and have dominated in the Western context at other points in time (Ariès 1976, Silverman and Klass 1996; Stroebe *et al* 1996).⁶⁶ The continuing bonds approach entails a concentrated interest in the various ways in which attachments and relationships are maintained with the deceased, thus challenging the prevailing discourse of the twentieth-century that bonds must be broken in order to permit 'healthy' investment of energy into new (living human) relationships (Klass 1996; Silverman and Klass 1996; Stroebe *et al* 1996; Walter 1996; Small 2001).

The act of releasing the lantern for Holly did not seem to be a 'letting go' in a sense of readings of Freud (1917) positing mourning as a severing of ties, forgetting and resolution (a return to 'normal') but, rather, as evident in the continuing bonds theories, marked recognition whilst readjusting an anticipated future with integration of what has happened. Releasing the Chinese lantern can

⁶⁶ For example, the influential work of Ariès (1976) considers the history of Western attitudes towards death from the Middle Ages through to the twentieth-century, identifying a shift from the 'public affair' of dying with gathered persons in the bedchamber sequestered to hospitals, in addition to changing notions of 'ownership' and 'appropriate use' of deceased bodies.

therefore be understood as a kind of ‘performative utterance’ akin to the example described by Davies (1997) of throwing soil upon the lid of the coffin with the corresponding spoken words of committal. Holly explained that “doing the lantern thing... was really quite powerful, seeing it kind of go off into the sky [...] something special for us to do”. In declaring their recognition of the loss of their much-wished for baby through this act, Holly and her husband ‘released’ their expectation for this pregnancy—to themselves, to one another and to potentially others—to become an embodied child in their lives whilst the marking of this absence constituted a memorial presence. Akin to the discussion by Klass (1996) of both internal and external worlds, Holly’s narrated experience regarding her loss thus highlights “the intersection of the past, the present, the personal and the social” (Small 2001 p42).

Since Holly conceived a second time soon after her miscarriage, she had had to “push it [thinking about the miscarriage] away” in order to cope; however, her approach towards her miscarriage loss was not of definitively ‘breaking bonds’ and she instead signalled intention in the future to find ways to maintain and express the significance of her experiences. With her second pregnancy at the time of interview going well and the would-have-been due date for her first pregnancy coming up, she had “been thinking about it more the last couple of weeks” including how she and her husband might mark and memorialise subsequent anniversaries. This signifies a rejection of ‘forgetting’ and ‘replacement’, and instead recognises grief as a potentially life-long accompaniment—albeit of varying intensities and temporalities (Rosenblatt 1996)—as bereavements and losses are integrated into ongoing lives (Marris 1991; Grainger 1998; Ribbens McCarthy 2006). Finding resonance with the continuing bonds approach for many of the participants’ experiences in my research, I posit that this example of the Chinese lantern release for Holly was not an event marking or signalling the annihilation or defeat of her grief regarding her pregnancy loss. Her grief was not ‘mended’ by the release of the lantern, since this would imply a return to a stable state as if bereavement and its consequences could simply be ‘undone’ (Davies 1997); instead the event, and as further evidenced in her discussion of a desire to enact subsequent memorial practices in the foreseeable future, marked her and, it seems, her partner’s commitments to retaining and continuing bonds to the miscarriage loss.

In addition to Holly's Chinese lantern, propelled by the wind filling the hollow balloon-like case and leaving a briefly visible glow in the night sky, candlelight featured in a number of participants' memorial activities. Lit candles tend to be short-lived object-activities, with the knowledge that the flickering flame present is limited by finitude of the wick or will eventually be blown out. Diane had attended and helped chaperone a number of memorial candle light services held in cathedrals in relation to her seven miscarriages. With most of her miscarriages occurring over a decade ago, her involvement with these memorial services over a number of years demonstrated the ways in which she continued to maintain bonds with her losses through remembering and memorialising them. As with the short durations in which candles are lit before burning out, memorial services are also events with necessarily limited time of an hour or so. Diane found it "comforting to know there [is] something every year to remember all the lost babies which[,] most of the time[,] are well and truly forgotten about". When I asked Diane whether the location of the cathedral held any significance, she replied that it would not matter to her where the service was held and that "I would be happy to attend any building if it was remembering lost babies". Given the wider context in which pregnancy losses are largely overlooked, public recognition through a cathedral service can confer symbolic and socially powerful connotations of acknowledgement and legitimacy – thus facilitating or constituting consolation.⁶⁷

Hence, such public religious buildings with traditional roles in death rituals like funerals and loss remembrance can be seen to partially compensate for a lack of wider social recognition and the 'marooned' online space enclaves of recognition and consolation (see Chapter 6). For Diane, the opportunity for individuals (namely women) to physically gather was important, producing a visible, material and emotional presence of collective memorialisation: "it is a lovely service where we write names cards and they are read out in the service to remember our babies" in addition to lighting candles. Though the cathedral setting held no additional religious ideological value for Diane, it was a space willing and able to support pregnancy loss grief rather than to deem it

⁶⁷ This is in contrast to other bereavements which tend to have different/additional spaces amenable for memorialisation. For instance, in the context of royal deaths, this can include condolence books in supermarkets and laying flowers at existing war memorials (Walter 2001).

pathological or ignore it entirely.⁶⁸ The rise of events such as miscarriage memorial services can be linked to the growing voices of pregnancy loss movements supported by their online accessibility/presences, but also the efforts of feminist theology to extend recognition of the need for religious support. For example, Ward and Wild's (1995) *Human Rites* book includes resources for the recognition of miscarriages and terminations. Elsewhere, there are theological reflections on stillbirth, including on hospital chaplaincy baptism practices (Newitt 2004). Feminist-influenced theology, Jones (2001 p228) suggests, can 'speak' to women who experience pregnancy losses and/or infertility to "give meaningful shape to this particular event [or series of events in their lives]". Many memorialisation practices neither demand nor reject commitment to organised religion/beliefs and instead pertain to a "more nuanced understanding of the widening spectrum of beliefs and related practices in societies such as the UK" (Maddrell 2009a p677). Thus, whilst some individuals may not hold robust beliefs, if any at all, around organised religion – they may still appreciate and benefit from the recognition of various kinds of pregnancy losses in a wider sense beyond their private/familial lives.

Another example of intentionally ephemeral or 'soluble' memorial practices concerns Fiona's apple pie making and eating in relation to her ongoing tending of an apple tree as memorial. Fiona explained that she took her young son to buy an apple tree on the first anniversary of her miscarriage which they then planted in the garden "in a place where we could always see from the window as a remembrance". Whilst the apple tree itself is a relatively long-term memorial 'thing', the fruits also constituted a form of memorialisation for Fiona: "[w]e then usually use the apples to bake something and share it with the family". The consumption of food is "an act of incorporation, as a social practice through which people make themselves, both biologically and socially" (Hamilakis 2002 p126; also: Lupton 1996; Bell and Valentine 1997; Probyn 2000) which, in this instance, is also a memorial practice. Fiona reflected on the experience of seeing the tree grow as she retrospectively conveyed, not having known of the pregnancy prior to the onset of uterine bleeding in miscarriage, that she would have liked to see and cared for the baby that could have been:

⁶⁸ However, there is also good reason to be cautious about potential pro-life motivations underpinning religious support/facilitation of pregnancy loss memorialisation specifically (Doss 2010) and in 'the foetus' generally (Casper 1999; Franklin 1999; Mason 1999; Stabile 1999).

“[t]he thing was basically just a stick when we bought it but four years on it’s flourished in to [a] beautiful tree that flowers and we can pick apples from every summer”. Layne (2003a p187, p188) notes how ‘redemptive nature’, by “always culminating in spring”, thus “offers the hope of death defeated and transformed”. Indeed, such symbolic elements of the apple tree were recognised by Fiona, commenting on the links between gestational progression and the cyclical blooming of botanical seasons:

it begins to bud and flower in spring, which is around the time the miscarriage happened. By Summertime/July which is coincidentally about midpoint between when the baby was lost (March) and when it should've been due (October) [s]o we have a tree with around a good 10 - 15 apples which are always big and healthy looking[.]

This links to an example of a ceramic mushroom urn, containing ashes of a stillborn baby, discussed in the Flemish context by Bleyen (2010). The participant in Bleyen’s (2010) research had photographed the ceramic mushroom urn throughout the changing seasons and added these to an album, much as one would with photographs of a living, growing baby over time. Through this material object, embedded within the outside environment of changing seasons, “the stillborn baby was being given a life course” (Bleyen 2010 p77), resonating, I argue, with the way Fiona spoke about the memorial apple tree in relation to her miscarriage.

The practices of baking and eating apple pie links to powerful discourses of domesticity, mothering, homeliness, generosity and nourishment. Fiona felt it was “kind of symbolic to see something good, something beautiful growing in the memory of the baby” and articulated the apple fruits as a kind of gift:

[the apple tree is] always having something to give us. As for making food from it, it just seems right to be doing something with what it's produced and not wasting it.

On one level, the apple tree is something that Fiona cares for and which she enjoys watching “spring to life each year”, adding with humour “it’s amazing to see it flourish really against the odds of my deadly gardening skills”. This links to earlier comments about ways in which ‘caring’ for memorial activities and

objects can entail ways to ‘actively parent’ following pregnancy losses (Layne 1999, 2000, 2003a; Garattini 2007; Murphy 2009). The apple fruits, as kinds of ‘gifts’, also quite literally nourish her and her living family as a source of food which, through the activity of a shared dessert, can be understood as a collective act of remembering the miscarriage loss – although whether her young son is currently aware of the meaning of the tree/fruit was unclear. Consuming the apples in such a context is a physical, bodily incorporation of ‘by-product’ memorial entities and becomes part of a wider activity of memorisation, bringing the social identity of the deceased baby into the presence of the emotional imaginary with lived practices of communal eating in the family unit. This resonates with comments by Davies (1997 p43), in the context of funerary meals, that “[i]t is in the household that life must go on and this makes it all the more important that it is in the house that the party should occur”. The example of Fiona’s thus links with the theme of using of food in consolation, such as that given to the bereaved by friends/family and shared at wakes, as well as literature foregrounding connections between and in the constitution of physical matter, environments, bodies and emotions (for example: Mol 2008).

As with some examples mentioned in Chapter 7 whereby tattoos and jewellery were not immediately legible or recognisable as denoting memorialisation of pregnancy losses, this is also the case for some ‘ephemeral’ practices. Anne, for example, described a memorial in the form of her approach within her ongoing life in which she sought to try new things as a testament to the memory of her stillborn son. This pertained partly to the complexity of not being able to easily determine specific anniversary (birth or death) dates so that some memorial practices, such as giving presents and eating birthday cake (Davidsson Bremborg 2012), were not considered suitable for the somewhat confounding situation. As Anne explained:

when it comes to the date that he died [and] the day he was born which is sort of a day after [he died] and [it’s] a confusing way around [...] but when we come round to that time, we’re definitely going to do something, we don’t know what it’ll be yet, we’ve actually just decided to erm to do erm something a bit special this year [...] Basically we’re doing a year of new things so we’re, we’re visiting places we’ve never been and we’re trying things we’ve

always wanted to try and have never got round to, reading books and watching films we've always meant to and never done, so we're just basically not putting anything off, we're going to have a year of doing new things, just stuff basically in honour of him.

Rather than choosing particular objects or events, Anne and her husband sought to memorialise through embodying a particular ethos in which the constant absence-presence of their son enriches their disposition towards multiple activities in their lives. In this way, he is a presence but one which is subtle in the sense that the reasons behind their dispositions were not immediately obvious, to the extent that Anne had been 'participating' in this living memorial for some time but had not yet explicitly explained this to her family. Anne and her husband's living memorial to their stillborn baby entailed plans:

to spend our free time during the whole year kind of doing LOTS of fun, interesting things erm and he's inspired that, you know. So we're doing those things, we won't be sad when thinking – although we might well be on his birthday and on the day he died – but through the year, we're getting to experience lots of new things and that's, that's because of him so that's how we're *choosing* really to... celebrate his life really.

This approach resonates with Anne's preference for the ultrasound images and her narration of her stretch-marks as affirmative gestures, remembering his life "as tiny as it was" rather than his death. Trauma shatters one's world, requiring the re-building of one's life as recognisably different (Janoff-Bulman and Berger 2000; Updegraff and Taylor 2004). Some of the activities Anne recounted doing so far were clearly stillbirth-related, such as lobbying for parliamentary support of Sands campaigns. In addition, as part of "looking for opportunities to do stuff", Anne described visiting some tourist sites: "we'd never been there before {laughs} even though it was horrendously expensive, it was a new thing, so we went in there". This can be understood as relating to the sensuous economies of late capitalism (Howes 2005 also cited by Lorimer 2012) in which, rather than the acquisition of material objects *per se*, embodied encounters are sought. Whilst some of these exceed capitalist gain since 'free' activities were also valued by Anne, it raises what I label as 'sensorial memorialisation' which might also include activities such as remembrance

scholarships (Foote and Grider 2010), travelling/holidaying to particular destinations to scatter ashes (Maddrell 2010) and fundraising with participation in marathons. Whilst these examples have particular temporalities, they ‘add’ to the life experiences of ‘living-on’ in ways that continue bonds with the subjects of loss. Anne’s embodied memorial speaks to particular qualities of her experience as the corporeal relationship of pregnancy made possible her son’s physical being, imagined and anticipated as a forthcoming and living baby. Although his biological living is now absent, his valued presence for Anne’s continues and—through her changed but ongoing life—develops, albeit in ways that are not necessarily immediately obvious to others in terms of memoriality.

Concluding Remarks

This chapter has considered the ways memorialisation, in (re)creating connections between the bereaved and deceased/subjects of loss, entail absence and presence in both material and emotional terms. In doing so, I have drawn from pregnancy loss and/or death studies scholarship to attend to a number of participants’ memorialisation practices and objects. This has included those pertaining to the physicality of deceased bodies (coffins, funerals, graves), symbolic items (teddies, angels), ‘index’ image-objects retaining traces to the now-deceased (ultrasonography scans, photographs, hand-foot ink prints) and deliberately ephemeral/transient activities (Chinese lanterns, eating apple-pie, lived/embodied memorials). The examples have illustrated that social identity and relations between bereaved and deceased are often “tied to the body – but not limited to the body” (Hockey and Draper 2005 p54). Themes of absence and presence have weaved throughout my discussions in various ways; for instance, the presence of deceased remains foreground the absence of embodied living, whilst the memorial objects and ‘index’ items in one’s home can become such pervasive presences representing absences that they stop being overtly noticed. In the fourth set of memorial practices discussed, I argued that the specific qualities of absence and presence in pregnancy losses, in terms of being brief ‘lives’ following by enduring embodied absence, are utilised. Thus, whilst some material ‘baby things’ used in memorialisation embody qualities of ‘babyhood’ such as softness, cuteness and preciousness (Layne 2000, 2003a) – some ‘ephemeral’ memorial objects and practices convey precarious and brief ‘life’.

The themes of spatiality and temporality have featured in this chapter on memorialisation and I am in agreement that “an investigation of the social life of things uncovers epochs and eras co-existing in the spaces of the present, whether their reach is far into the past or onwards into an indeterminate future” (Hockey *et al* 2005 p139). I also support the notion that the physical body space is important in many ways to memorialisation, but also add that the nature of many pregnancy loss experiences require and permit flexibility regarding this. As for Isabel, it is possible to ‘transfer’ emotional connections from one site associated with her pregnancy loss son to another location more proximate through objects like flower wreaths. In addition, in the absence of the actual physical remains of participants’ pregnancy losses or, as for Diane, of most of their pregnancy losses – other objects and events can be especially valuable. Some forms of memorialisation become pervasive features in one’s life and inhabited spaces, regarding particular rooms or pieces of furniture in their homes but also their own skins and bodies as with memorial tattoos (see Chapter 7). Familiarity, however, does not necessarily equate to forgetting and can instead attest to successfully incorporating absences-presences and continuing bonds in the ongoing lives and inhabited spaces of the bereaved. In various ways different forms of memorialisations constitute experiences which participate in ‘temporal ordering’ and narration, such as in the research project, around “the pivotal event” (Layne 1996 p132) of pregnancy loss.

Memories, narratives and memorialisations of pregnancy loss are shaped in wider contexts with a variety of responses possible such as acceptance, rejection, encouragement and dismissal. Social attitudes regarding pregnancy losses and provisions for grieving and memorialising mutually influence one another and produce particular contexts in which these embodied (material, discursive, emotional) experiences and understandings are negotiated. As discussed in Chapters 4 and 6, this involves partners, family members and work colleagues but also online support group users who may promulgate memorialisation attitudes and approaches absent in much of one’s ‘offline’ life. Given the wider cultural denial and dismissal of pregnancy losses prominently argued by Layne (1999, 2000, 2003a, 2003b), memorialisation practices and objects can be understood as resistance to normative notions that these experiences do not ‘count’. That pregnancy is a *relationship* (Rothman 1989; Franklin 1991; Lupton 1999; Woliver 2002) has implications for Davies (1997

p42) comment that “[b]ehind all grief lie experiences shared with the one who is now dead”. In the context of pregnancy losses, this includes particular embodied and corporeal experiences as reflected in the body as a site for memorialisation through, for example: wearing jewellery and the acquisition of tattoos (Chapter 7); visiting and tending graves; ‘caring’ for memorial ornaments and toys; and ‘living’ memorials. This chapter on memorialisation, in foregrounding material-emotional relations, has brought together a variety of ways in which ‘loss’ has featured throughout this thesis – leading onto my closing discussion.

Closing Discussion

In this closing chapter, I will outline a number of key conceptual and empirical contributions as organised around three intersectional nodes which I have developed across the thesis. These three nodes foreground the important stakes in researching experiences of pregnancy loss and are as follows: material-emotional-relational bodies; sensitivity, resistance and pregnancy loss; and feminist reproductive politics, loss and death in geography. These three nodes also highlight some of the ways that my research has been influenced by, but also diverged from, previous research on pregnancy loss, regarding methodology and/or in the discipline of geography. For example, there are a number of ways in which I differentiate my research from the work of Linda Layne (1996, 1999, 2000, 2003a, 2003b, 2004, 2006, 2010b, 2012), the anthropologist who I have cited prominently throughout the thesis. Layne's work, also using the label 'pregnancy loss', has been incredibly valuable to my research, constituting a source of inspiration and many rich insights. However, there are also differences in terms of approaches towards such research in addition to the focal topic content.

As discussed in the Methodology chapter, my research has entailed me largely 'suspending' disclosure of whether or not I have personal experiences regarding the research topic. In contrast, Layne foregrounds her identity in her research as a woman who has experienced multiple miscarriages and member/user of various support groups. At times, as others have noted (Reagan 2003; Keane 2009), this overt investment may be a particular factor underpinning limits to critical analysis. In particular, I find a number of oversights in Layne's work such as: largely reductive assumptions about the emotional responses and meanings about pregnancy losses; the predominant omission or otherwise sidestepping of termination; and a limited critique of (face-to-face) support groups. These are all aspects which I have sought to engage further in my own research, as well as challenge the dismissive tones which I identify in Layne's (2010b) 'blissful ignorance' reproach towards urine-based home-kit tests (discussed in Chapter 3). In addition, although both identifying as feminist academics, my affiliation to the discipline of geography has meant that spatiality has been very much at the forefront of my research.

My thesis sought to further understandings of pregnancy loss experiences and make particular interventions into the discipline of geography through the empirical focus of pregnancy loss. In doing so, I have utilised literature: on qualitative social research methodologies; from multiple disciplines, including anthropology, sociology and history; from fields, like that of death studies; and from sub-disciplines, such as the geographies of death and dying, emotional geographies, feminist geographies, geographies of the body and online geographies. The first node emphasises bodily experiences as physical, emotional and social as I return to the opening justification that recognition of these interconnections can enable richer accounts of pregnancy loss. The second node brings together the issues of sensitivity and resistance to foreground methodological and thematic aspects as ambivalent, precarious and yet vital. The third and final node concerns my efforts to re-orientate understandings of reproductive politics, loss and death within geography. I will then outline several future research directions before providing my final closing remarks.

Material-emotional-relational Bodies

I sought in my research to “create a woman-centered discourse of pregnancy loss” (Layne 2003a p239) which “reframe[s] pregnant women as the subjects of gestation” and “re-envelops the foetus within the pregnant body” (Tyler 2001 p81). Whilst post-partum and separated embryonic, foetal and baby bodies feature in the thesis (notably in Chapters 5 and 8), pregnancy as a *relationship* between women and foetuses is reiterated. In the events of pregnancy loss, relationality does not necessarily cease since (redefined) bonds continue as indicated by many of the cited examples of memorialisation practices. In an attempt to disrupt the tendency to privilege embryos, foetuses and babies at the expense of women, I repeatedly sought to refocus attention on the material, social and emotional bodies of women themselves. As such, my research has elaborated on the embodied experiences of women who have had pregnancy losses, rather than primarily on foetal/baby bodies. My desire to focus on embodiment also responds to a divergence I identify in the pregnancy loss literatures, whereby the social sciences tend to focus on grief in a manner which often backgrounds the bodies of women and the medical literatures largely focus on the physiological events of pregnancy loss without appreciating the complex, extensive, wider experiences. Thus, my interest in material-

emotional bodies is a strategy both to resist the tendency to efface women when the foetal subject is privileged and to develop accounts of pregnancy loss which attend to aspects which are otherwise largely overlooked.

Bodies, the “most immediately and intimately *felt* geography” (Davidson and Milligan 2004 p523 italics in original; Rich 1986), feature prolifically and prominently in the thesis and do so in relation to other spaces such as hospitals and cemeteries. Amongst others, this has included bodies: living, conceiving, pregnant, waiting, distressed, bleeding, birthing, no-longer-pregnant, lactating, bereaved, crying, grieving, remembering, talking and typing. Bodies are also social, involving relations between women and their embryos, fetuses and babies before, during and after pregnancy losses, but also with others such as partners, family members, friends, medical staff, work colleagues, online group users, tattooists, strangers and so on. That some pregnancy losses are considered deaths—validated legally, medically, personally and/or socially—means encounters with *deceased* embryo, foetal and/or baby beings; for others, in relation to their own encounters, there is intense ambiguity as to what the bodily fluids and ‘body-like’ materialities from ended pregnancies ‘are’, potentially betwixt-and-between menstrual blood and normative corpses. This issue concerns matter deemed ‘out-of-place’ and ‘out-of-time’; as Douglas (1966 p36) argues, discomfort towards, and potentially the rejection of, matter ‘out of place’ can concern “any object likely to confuse or contradict cherished classifications”. Pregnancy loss materiality, ‘unformed’—“an apt symbol of the beginning and of growth as it is of decay” (Douglas 1966 p161)—or otherwise in undesirable form, disrupts the presumed qualities anticipated in reproduction of living and progressing bodies during pregnancy and post-partum.

Countering the culturally-pervasive narrative of joyful pregnancies, encounters with ambiguous matter discussed in this thesis have included: deceased embryos, fetuses and ‘babies’ inside living women; encountering unexpected bleeding and expulsion of foetal and placental bodily materiality; premature birth; onset lactation following loss; underdeveloped or anomaly pregnancies; seeing/holding stillborn babies; and tiny coffins. This raises the issue that death involves the transition of bodily matter which, in instances of pregnancy loss, entail additional and potentially disconcerting qualities of ambiguity. As Woodthorpe (2010) notes, it is not necessarily the knowledge that

death does occur/has occurred *per se* which evokes emotional, social distancing in contemporary Western societies but rather the thought of, or contact with, the physiological matter and decomposition of, dead bodies. Whilst aversion and fear were responses towards the materiality of pregnancy losses for some—whether concerning residing in the internal body (as with missed miscarriages or pre-partum stillbirths), tactile contact with the external body (as with feeling and/or touching pregnancy losses intra- and post- partem) or more physically distanced viewing—feelings of sadness and profound loss were often also recalled. The tension between these sets of feelings, and the difficulty of reconciling resultant actions as demonstrated by Fiona, was also marked through the indeterminacy of language used to describe ‘what’ or ‘who’ was encountered (Murphy and Philpin 2010).

Embodiment denotes “our *being* through our bodies” (Moss and Dyck 2002 p10) and constitutes both a primary condition for the project—which depended on embodied, recollecting and ‘speaking’ participants—and a theme in the research. In addition to bodily interiors (Chapter 3), surfaces (Chapter 7) and the flows between bodily internals and externals (Chapter 5) – I discussed relations to other body-selves (Chapter 4), ‘reconstituted’ bodies online (Chapter 6) and memorialisations as embodying simultaneous absence and presence (Chapter 8). Always changing, physical bodies are emotionally and socially embroiled in the accumulative, ‘lived out’ and ‘lived through’ nature of experience. Women who have physiologically had pregnancy losses, therefore, can have direct experience of a whole range of bodily aspects, pertaining to: their interiors as imagined by themselves and others, and technologically ‘viewed’ in medical and domestic settings; external skins, contours and bumps; fluids, such as blood; and materialities like embryo, foetal and baby bodies. However, owing to the wider cultural denial of pregnancy losses and general societal discomfort towards particular elements of ‘death’ and ‘bodies’, many of these embodied experiences can be disavowed, trivialised or (self)censored. Subsequently, even when narratives about pregnancy loss are ventured in the presence of others – particular aspects deemed ‘too graphic’ or otherwise squeamish may be ‘sanitised’ or euphemised. In contrast to this predominant and everyday situation, I sought for my research to offer an alternative opportunity in which participants could openly discuss these aspects, if wanted.

Resonant with the quotation by Winterson (1996) which opened the thesis, I have sought to consider some of the ways that the physical and emotional bodies of women who experience pregnancy loss retain palimpsestic, but sometimes largely indiscernible, traces. For instance, Chapter 7 considered how some participants utilise their physical bodies to ‘speak’ or convey something about their pregnancy loss experiences in ways—such as with memorial tattoos—which are not necessarily visible, or intended to be legible, to others. Whether unintentional in their production or deliberately acquired, a variety of bodily marks, alterations and sensations can “illustrate biographical stories” and serve as “communicative devices” offering support “as people strive to (re)tell plausible self-narratives” (Kosut 2000 p96). I have sought to bring ‘the body’ back into focus as a material entity, recognising embodiment as entailing fleshy physicality—of organs, tissues and fluids—as well as emotionality, and situate biology in relation to social contexts. This echoes a wider advocacy in geographies of health (Hall 2000) and links to Lindemann’s (1944) pioneering work which argued that bereavements alter the ‘sensorium’. However, the ways in which bereavement and grief are bodily experienced tends to be disregarded in social contexts (prompting hiding) and has been overlooked in a vast array of subsequent academic accounts (Hentz 2002). Whilst much grief scholarship attends to cognitive dimensions, Hentz (2002) argues there has been a relative lack of interest regarding how bodies ‘remember’ and ‘encode’ grief such as visceral responses like tiredness on dates retrospectively recognised as bereavement anniversaries.

There is resonance also with regards to the ways in which existing pregnancy loss literatures have largely focused on validating the cognitive and emotional dimensions of grief with less interest in further exploring ‘the body’. Certainly, previous academic accounts of pregnancy losses implicitly concern bodies and tend to mention common experiences of bleeding, cramping and passing matter but often in ways which largely concede to a biological domain. As I hope to have shown, bodies are physical entities *and* always already social, discursive, emotional and relational. Pregnancy loss experiences are *shaped* by, for instance, the routinised and prolific use of reproductive technologies interacting with physiological bodies, including around urine tests, in medical and ‘domestic’ settings, and ultrasonography scans. There are aspects which do not leave physical marks on the body but nonetheless elicit visceral sensations

and alterations (Chapters 3 and 7). For instance, using home-kit pregnancy urine tests may be distressing experiences but do not leave tangible ‘evidence’ on the material body as do stretch-marks and puncture sites/bruises of blood tests, at least temporarily. However, the embodied experience of using urine test kits can remain present in one’s recollected body-self history, potentially emerging emotionally and sensorially in abrupt ways with the onset of subsequent menstruation and the use of additional pregnancy tests (Chapter 3).

Sensitivity, Resistance and Pregnancy Loss

Entailing an array of emotionally-fraught, ‘sensitive’ topics, pregnancy losses are difficult, deeply distressing experiences for many – yet I resist the implication that this therefore disqualifies discussion. To self-censor such research from ever occurring would be another way in which pregnancy losses are neglected from (academic and wider) recognition. Ethics in this research were processual and sought to be emotionally-attuned, with recognition that there can be no guarantees of ‘successful’ or apt ethical deployment despite efforts to be constantly vigilant, sensitive and willing to revise decisions, such as those about conversation and conduct within interviews (Corbin and Morse 2003). Emotional dynamics are more than just practical issues to be ‘controlled’ since “emotions are integral to research relationships” and constitute rich interpretive resources (Bondi 2005 p232). Attending to these shaped the kinds of ‘data’ produced, drawing my attention to particular examples in sometimes intensely visceral, emotional and ‘haunting’ ways. Though not always unanimously achieved, I sought not to ‘shy away’ from the intensity of emotions involved in participants’ experiences shared during research encounters. As Langer (1997 p54-55) articulates in the context of Holocaust testimony, this is because “[p]ainful memories are not always disabling, and narratives about them [...] rarely “liberate” witnesses from a past they cannot and do not wish to escape”. Talking about pregnancy loss, as in the interviews, is thus not a ‘solution’ to painful experience but nor does it need to be deemed a ‘problem’ either. From this perspective, to prohibit such research from occurring or to close down all ‘intense’ discussions in the research poses—rather than solves—ethical queries, such as about different channels of silencing in operation.

In this way, although inevitably accompanied by hesitations about efficacy, I identify feminist sentiments of ‘resistance’ at the basis of my research

with attempts to: draw on multiple experiences of pregnancy loss; acknowledge the ‘personal is political’; and offer ‘small’ gestures in research encounters of emotional support and practical signposting to resources. My project, and the kinds of discussions about pregnancy losses I have developed within it, can be seen to constitute a form of resistance to the wider societal approach of silence, denigration and marginalisation. This is in the vein of a particular propensity for feminist researchers to identify forms of resistance given that “[t]he image of women’s unquestioning subservience is hard for us as feminists to accept, both in examining ourselves and in interpreting the lives of those with whom we conduct research” (Lewin 1998 p164). Women’s relationships with biomedicine has been a particularly key domain for such findings, with feminist researchers locating forms of resistance offering reassurance that hope persists (Lewin 1998). Forms of resistance can be conscious, unconscious, direct, indirect, overtly disobedient, quietly subversive, premeditated and, as Wade (1997) notes, opportunistic. The identification of subtle resistances rejects “[t]he notion that the act of resisting must entail direct communication or confrontation [which] is based on highly masculinist assumptions and obscures recognition of acts of resistance that are not stereotypically masculine in nature” (Lorentzen 2008 p74). This latter notion fits more aptly with Martin’s (1987 p188) defining of ‘rebellion’ as “[f]orcing or persuading other people to change the way they talk or act, beyond the single instances of resistance [for unknown/future others in similar positions to benefit from]”. Within my research, there were important and admirable examples of this, such as Anne’s involvement in educating midwives on their treatment of patients who have stillbirths and lobbying for funding from parliament for further stillbirth research.

Differentiated to that of ‘rebellion’, Martin (1987 p187) describes ‘resistance’ broadly as the refusal “to accept a definition of oneself and saying so, refusing to act as requested or required”; two examples of which in her research resonate with those in my own on pregnancy loss. The first example of resistance, in relation to menstrual bleeding in the workplace, is “turning private spaces to seditious purposes”, such as using toilets as a kind of ‘backstage’ for solidarity (Martin 1987 p177). With menstruation largely deemed a ‘disgusting’ and ‘shameful’ bodily process, Martin (1987 p97) recognises potential: “if what my body does must be kept secret, then I can use that opportunity to keep other things I do secret also”. For Rosie, workplace toilets

had been the setting of a frank conversation about pregnancy loss and infertility with an ‘acquaintance’-colleague. Given the perceived workplace atmosphere that such topics were not suitable for open discussion or could be the subject of duplicitous conversation, the two women aired their experiences in the semi-private setting of the toilets and offered one another advice and encouragement. Martin’s (1987 p177) second example concerns menopause whereby resistance is enacted through “publicly nam[ing] their state, claiming its right to exist as part of themselves in the public realm”. A number of memorialisation practices could be discussed in these terms; for instance memorial jewellery and tattoos can invoke conversations about pregnancy loss. In addition are occasions when participants had openly and unabashedly, at least at the time, stated their occurrences of pregnancy losses. For instance, Anne’s encounter with a pushy supermarket cashier in which she stated her recent stillbirth and Gemma telling a variety of persons about her foetal anomalies termination. Whilst both women described ambivalence or regret retrospectively, they nonetheless engaged in a refusal to suppress their experiences by vocally communicating them in ‘everyday’ contexts where such disclosures are unexpected.

Yet there are concerns that ‘resistance’ “is rapidly becoming a word that covers anything, defines itself, and may be said to exist because we insist that it does so” as well as concern that its deployment can negate the ways in which hegemonic complicity occurs simultaneously (Lewin 1998 p164). I am aware that my framing of the above examples may not be considered in such ways by the participants cited and that it is important to also consider the limitations regarding these activities. As I discussed in Chapter 6, in relation to online support groups, particular exclusions and hierarchies can be reiterated or go unchallenged. In addition, the support groups can constitute enclaves, characterised by the concern held by some that their online ‘disclosures’ of pregnancy losses *inside* support groups might ‘leak’ out and become known to wider others such as Facebook friends. As with the earlier example mentioned regarding Rosie in her workplace toilets, there is a degree to which the online support groups can *contain* recognition/awareness of pregnancy losses and continue to sequester this rather than effect changes in wider social contexts. This links to discussions in my Methodology chapter about negotiating tensions between exposure to risks and prospective benefits from pursuing challenging discussions about pregnancy loss, for oneself and others. Another sentiment of

‘resistance’ concerns the ways I have academically situated the project in relation to feminist geography, seeking to challenge the logics of ‘male-stream’ geography (Rose 1993) through pregnancy loss. If researching fleshy, leaky, female bodies is something of a difficult topic for ‘squeamish geographies’ (Longhurst 2001), then researching deceased and bereaved bodies in reproduction is especially so. As I will elaborate in the third node below, I have subsequently challenged feminist refusals to engage with pregnancy loss *and* refuted that the ‘who’ and ‘where’ of dying, death and bereavement are already and definitively known.

Feminist Reproductive Politics, Loss and Death in Geography

Emphasising notions of relationally and socially attributed life, personhood and death (Franklin 1991; Morgan 1996; Addelson 1999; Hallam *et al* 1999; Hartouni 1999; Layne 2003a) has allowed me to retain a commitment to feminist reproductive politics as I sought to attend to the meanings women themselves hold about their pregnancy losses. With my particular interest in body spaces, I sought to develop a series of accounts about pregnancy losses. This included recognition that some pregnancy losses are legally and medically deaths or are considered as such by those intimately involved, highlighting pregnancy loss as a topic for further consideration in the growing sub-discipline of the geographies of death and dying. This is not without caution and the way in which this could unintentionally invite or permit pro-life sentiments remains a serious ‘dilemma’ (Kitzinger and Wilkinson 1997), reiterating the need for a critical consideration of the legal and political ramifications that the vocabulary of death may have (Kevin 2011). To be clear, I do not argue for *all and every* pregnancy loss to be deemed/labelled a death, bereavement and/or loss but, instead, to recognise that this is how *some* women view these events. This is sometimes also legally and medically legitimised, as in stillbirth and neonatal death, and/or validated by their extended social networks, but not necessarily. That some pregnancy losses are legally, medically, personally and/or in certain social settings/groups considered deaths, need not erode other facets of feminist reproductive rights such as demands for safe, accessible and cheap contraception and termination facilities, women’s healthcare, and support for childcare. My research has brought together two sub-disciplines—feminist and

death and dying geographies—which, given the stakes, I consider crucial in the context of pregnancy losses.

My use of the label ‘pregnancy loss’ was a deliberate decision, amenable to a variety of readings that neither necessitate nor prohibit identification with that of ‘death’. ‘Loss’ can be understood in a physical sense, referring to the materiality of ended pregnancies whether this be blood, ‘clumps of cells’ (Fox 2000), embryos, foetuses, babies and/or, in ectopics, fallopian tubes. The naming of these material entities as ‘losses’ does not necessarily require particular emotional responses. Another understanding of ‘loss’ refers to curtailed or ruptured expectations, hopes and dreams which may prompt the (re)construction of social identities for oneself (as a mother) and others (as one’s child). For some participants, recurrent pregnancy losses and fertility complications meant that particular aspirations in relation to biological kinship entailed tremendous emotional turmoil and uncertainty about their futures. Subsequently, in trying to conceive or during later pregnancies, anxieties regarding this array of losses could crystallise and re-emerge in experiences of, for example, using urine home-kit pregnancy tests with feelings of haunting precarity (Chapter 3). The physiological circumstances and/or emotionally traumatic past experiences for some meant abandoning earlier familial ‘dreams’ and adjusting to new prospective futures, such as pursuing adoption. There can also be a loss of prior beliefs and orientations, such as of innocence, regarding dominant narratives of reproduction as natural, joyful and happy (Layne 1996, 2003a, 2003b, 2006). The lexicon of ‘loss’ can, as I have suggested, accompany accounts of bereavements by death but also other kinds of disruptive and grief-inducing life events (Updegraff and Taylor 2000; Davies 2005) such as relationship breakdown/divorce (Rosenblatt *et al* 1976), chronic illness (Charmaz 2002, 2008), ‘fading’ identity in old age (de Medeiros 2009), dementia (Hallam *et al* 1999), industry closure (Walkerdine 2010), and displacement by disaster events such as Hurricane Katrina (Curtis *et al* 2007; Otte 2007) amongst other circumstances of homelessness (Robinson 2005).

I sought to accommodate complex, multiple understandings of ‘loss’, with recognition that such experiences have specific and differing “contours” (Kevin 2011 p849), in order to attend to an array of spatial contexts. In this research, I have explored a range of ways in which different participants’

experiences of pregnancy loss shaped, and were shaped by, various spaces. In addition to—and yet always involving—body spaces, this has included ultrasonography rooms as locales in which no-longer-progressing, deceased and/or shortly-ending pregnancies are encountered (Chapter 3). Another set of examples concerns various mourning and memorial activity locations such as graves (official, informal, proxy), cathedrals, beaches, and homes and gardens (Chapter 8) but also other sites that cannot necessarily be anticipated such as the way in which wearing of memorial jewellery can spark enquiries and conversations in which experiences of pregnancy loss are shared. Particular spaces featured in the thesis a number of time in different ways; for instance, toilets and bathrooms can be locations in which pregnancies are ‘revealed’ via urine-tests (Chapter 3) and end with bleeding/passing matter (Chapter 5) as well as sites for reciprocated emotional support with others (Chapter 4).

The attention to the spatiality of pregnancy loss in this research has also highlighted a number of differences in contrast to other experiences or contexts of loss, death and bereavement. For example, Chapter 5 included a discussion of the ways in which some pregnancy losses can entail encounters with embryonic and foetal bodies in toilets: spaces not usually considered, in academic literature or more broadly, to be a space of death and dying. Such toilet/bathroom settings tend to diverge starkly in physical, social and symbolic terms to the efforts which are often made in professional funeral parlours to provide a consoling and aesthetically sanitised environment in which deceased bodies are encountered. Careful management of various aspects of viewing and visitation in funeral parlours and chapels of rest in hospitals, for instance, are thought to support the bereaved and facilitate their grieving (Worden 1993). Yet encounters with such bodies/materiality in toilet spaces regarding, for example, miscarriages often involve contact with taboo and ambiguous bodily fluids, entities and textures. As a result, these experiences can be deeply frightening, including with uncertainties regarding the intensity of uterine bleeding (as explored in Chapter 3), and invoke additional feelings of abjection towards what is felt and/or seen. Some participants articulated emotional tensions resultant from such scenarios, with strong and not easily reconcilable responses including love for the ‘baby’ alongside disgust at ambiguous, dead/non-living matter.

As evidenced in the aforementioned example, some pregnancy losses can differ in important ways from other kinds of losses/deaths. This also has implications for various aspects of scholarship. For example, Chapters 7 and 8 both highlighted the ways in which pregnancy losses can leave little to no physical ‘mementos’ to be utilised in subsequent memorialisation practices alongside reluctance, or hostility, from others to engage in socially recognising the validity and desire for these. Subsequently, when the bereavement is not of a ‘person’ according to criteria of having lived post-partum (i.e. an infant or adult), there are additional difficulties in constructing ‘durable biographies’ (Walter 1996) and/or otherwise maintaining ‘continuing bonds’ (Rosenblatt 1996; Silverman and Klass 1996; Silverman and Nickman 1996; Stroebe *et al* 1996; Small 2001). One of the key contributions of the thesis has been to foreground an array of spaces which might otherwise be overlooked as locations of loss and/or death; when considered in relation to pregnancy loss experiences, with presumptions in the academic literature about the subjects of death and dying challenged, these geographies come into focus as significant. As such, the thesis has entailed reflection on normative assumptions about *who* dies (post-partum/‘individual’ children and adults) and is bereaved in accordance with particular *criteria* (social- and biological- life), the *temporalities* and *processes* of dying (sometimes prior to, rather than succeeding, birth) and the *spaces* of these experiences.

In challenging that the subjects of death and bereavement are already known in the geographies of death and dying, it is essential to retain feminist emphasis on women’s bodies, lives, relations and emotions. I consider pregnancy losses as neither *firmly* inside nor *relegated* outside of the remit of the geographies of death and dying, instead positing my framings of the topic as an ‘ambivalent, feminist, emotional geographies of loss’. Such an approach simultaneously seeks to acknowledge the significance of pregnancy loss experiences for some whilst refuting prescriptive expectations about emotional responses or otherwise reactions. To disregard pregnancy loss altogether further denies and negates many women’s lived experiences (Layne 1999), but this does not mean that all women’s narratives (like those propagating pro-life stances) must be ‘validated’ by feminist researchers (Kitzinger and Wilkinson 1997). My research corroborates that in hearing an “expanded account of women’s reproductive experiences, feminists will clearly have to contend with numerous

foetal interpretations, gendered meanings, and political stances” (Oaks 1999 p195). Pregnancy loss is certainly challenging to research – it “is not a nice topic” but remains “a fact of life” with potentially significant emotional as well as physical implications (Layne 2003a p249). For this reason, academic exploration of pregnancy losses are valuable, potentially benefitting study participants and enriching literatures to provide fuller or additional understandings of these experiences. This has relevance for policy implications, such as hospital protocols, and the diversity of spatialities I have discussed highlights the scope to further improve an array of environments within which embodied understandings and relationships regarding ‘loss’ are negotiated.

Future Research Directions

Just as bodies “cannot be static” with the constant changing of life (Oksanen and Turtiainen 2005 p122), this is also the case for research trajectories which are inevitably open to additional understandings still to be gleaned from prospective research engagements. The ways in which different persons experience pregnancy losses as related to particular notions of normative reproduction and ‘appropriate’ reproducers constitutes a significant avenue for additional research. This recognition invites further work on cultural differences and the developing world context, as mentioned in the introduction chapter (van der Sijpt 2010 on Cameroon; also Ryan 2009 on assisted reproductive technologies). Attitudes regarding who is deemed a suitable ‘reproducer’ entail factors such as race, class, disability, sexuality, marital status and age (Luker 1996; Ladd-Taylor and Unmansky 1998; Woliver 2002; Kuttai 2010) with historical traces and precedents (Reekie 1997). Not excluding all of these factors, amongst others, the theme of age and ‘generational relations’ emerged in my research. For instance, I was sometimes positioned by participants as a ‘young’ woman whose reproductive life was forthcoming rather than past, current or surplus (Methodology chapter). Several participants described their own experiences of pregnancy and/or pregnancy loss at a ‘young’ age (Carla, Lara, Fiona and Gemma) or made observations about ‘young’ pregnancy and motherhood as stigmatised based on the treatment of their relatives (Siobhan). Social anxieties pervade debates on teen pregnancy, notably around notions of promiscuity and contraception (Fine and MacPherson 1992) because “[t]een pregnancy operates outside the norm of legitimate

reproduction, marking it as a site of moral concern and state control” (Pillow 2006 p216). Relevant to this, the concepts of ‘teen’, ‘young’ and ‘older’ pregnant women/mothers are historically, socially, culturally and politically negotiated, as well as shaped by the aforementioned varying axis of differences.

Since reproductive decisions should include being “able to choose legal, safe abortions [... and being] able to choose, rather than be coerced and shamed, to continue their unplanned pregnancies” (Woliver 2002 p4), the positioning of teenage and ‘young’ pregnancy as a problem curtails the possibility of genuine ‘choice’. If a lower teen pregnancy rate is implicitly deemed a success, there are serious questions to be raised about whether the role of terminations in ‘achieving’ this is really quite so laudable. That is, given the stigmatising rhetoric towards teen pregnancies, termination can feature in public discourse as ‘the right choice’ or a ‘solution’ given—as Woliver (2002) notes—the array of societal ills teen mothers are blamed for. Drawing on wider dismissive attitudes, this may unfairly position other pregnancy losses such as miscarriages as ‘for the best’ also. There are several implications which could be considered: the additional negation of any grief or emotional ambivalence and thus also potential memorialisation practices; peer-to-peer knowledge about pregnancy generally and pregnancy loss specifically, such as when and where to turn to for information and/or medical assessment; the role of educational institutions; and treatment by medical staff who may, knowingly or unwittingly, channel judgmental attitudes in different settings such as during GP appointments, ultrasonography scans, during labour/birth, and in the delivery of postnatal care. Numerous tenets of participants’ experiences hold relevance for thinking through some of these, such as Gemma who had previously considered foetal anomalies primarily relevant to ‘older’ women than herself, Lara who was anxious about recurrent miscarriages of planned pregnancies in her future and Carla who described some of the medical staff encountered in her first pregnancy as “the most horrible people I’ve ever met”.

There is scope to reflect further on issues of public engagement with the topic of pregnancy loss and certainly the aforementioned interest in teenage and ‘young’ pregnancy loss could have significant policy ramifications. In addition there are other issues of public concern, including the prospect of ‘Missing Angel’-style bills operating in some US states whereby certificates of life, as well

as of death, are officially issued to parents of stillborn babies whereby stillbirth is regarded in the US as those over 20 week gestation as opposed to the UK definition of 24 weeks or more (Doss 2010). Communicating and translating research findings beyond academia requires careful reflection on how to adequately convey the complexity and diversity of pregnancy loss experiences. This endeavour—as well as issues such as that of certification potentially on the UK horizon—would require attentiveness to feminist reproductive politics. For instance, dispersing narratives of pregnancy loss outside of academia and beyond the enclaves of (online, face-to-face) support groups must capture a diversity of views without propagating intolerance. Doing so is certainly easier said than done, but one potentially productive approach could be with ethnographic fictions which bring together research ‘data’ material to produce composite stories able to appeal to reality “in the sense that things *like these* happened to people *like these*” (Angrosino 1998 p101 italics in original; also Inckle 2005, 2010). Ethnographic fiction stories, ideally rendered accessible and widely available, could enable readers “to experience something of what the people among whom we conducted our research have experienced” and do so in a manner which addresses “life as it is lived, rather than life as it is analysed and dissected through the language of positivistic science (Angrosino 1998 p97).

There is also scope for future research to consider the past experiences of women in older generations, inviting recognition of the ways pregnancy losses have been responded to in other eras, places and circumstances – bearing in mind that these narratives may be very different and even oppositional to the dominant one of grief explored in the contemporary pregnancy loss literature (Reagan 2003). Pregnancy losses are experienced in diverse ways, not necessarily always seen as sad, distressing or traumatic events (Keane 2009), and may be considered ‘best left in the past’. However, some women vividly recall their pregnancy losses and grieve these many years/decades later (Letherby 1999; Davidson 2007; Murphy 2009), as was the case for participants like Caroline, Diane and Lisa. Additionally, participants sometimes mentioned those for whom this was the case in their interviews in terms of their own mothers or older family friends. Further consideration of familial histories could quite significantly widen the known scale of women, as well as potentially their partners/familial others, affected by pregnancy losses. It also raises questions about the prospect of extending recognition and negotiating support which

might be appreciated presently. Of course, not all women are or, if intergenerational reproductive histories were considered further, would be interested in recollecting their experiences and/or memorial activities – yet others may welcome the possibility. Whilst some activities are not retrospectively possible for many of those whose losses physically occurred long ago (seeing/touching the foetus/baby, burial/cremation, taking photographs, hand-foot ink prints), some mourning and memorialising activities *may* be of interest such as art therapy (Seftel 2001, 2006; Douglas and Fox 2009), creative writing and participating in official or private memorial services.

Research attending to older generations could provide opportunities to bring these experiences into recognition in their own right *and* enable exploration into the ways emotions and memories can resurface across/in-between body-selves in later generations' reproductive (multi-generational) lives. Given that one's mother is often a key source of support regarding pregnancy losses (Cecil 1994) or, counteractively, can compound distresses with insensitivity – questions are raised about intergenerational experiences of pregnancy losses. There is evidence from my research that past experiences of familial others' pregnancy losses can feature in the recent, current and forthcoming lives of later generations (between mothers and daughters or between sisters). My reading of the concept of postmemory (Hirsch 1997) in Chapter 3 challenges the notion of distinct, individual, bounded body-selves and experiences (see also: Dixon and Straughan 2010; Abrahamsson and Simpson 2011; Lea 2012). Postmemory suggests that another's past (reproductive) experiences can 'travel' across bodily boundaries to unintentionally re-emerge in the present lives of later generations, resonating in ways which are felt but not necessarily as clear manifestations. If postmemory is understood as a resurfaced and displaced remembering—a simultaneous absence and presence which can have 'real' effects but remain non-verbalised/un-verbalisable—this could have significant implications for ongoing debates about responses to recent, current and future pregnancy losses. Thus, thinking about the concept of postmemory highlights an opportunity to 'trace' an inter-generational account of pregnancy loss which would fundamentally recognise the ways in which kinship is socially and biologically produced, and contribute to multidisciplinary work on 'intergenerational' relationships (Peskin 2000; Pillemer and Lüscher

2004) including that specifically concerned with bereavement in ‘the family’ (Gilbert 1996; Baddeley and Singer 2010; Forhan 2010).

* * *

The contribution of my thesis has been to draw attention back to bodies in thinking about various experiences of pregnancy losses. The physicality of bodies tend to be paradoxically overlooked in nursing encounters in medical settings (Murphy and Philpin 2010) and, I argue, much of the relevant existing academic social science and humanities literature. Drawing on participants’ narratives, I have sought to foreground pregnancy losses beyond medical events as experiences in which both themes of materiality and emotionality are central. My thesis is comprised of (re)collections emphasising the embodied and relational experiences of pregnancy losses, as enabled by my bringing together of feminist and death and dying geographies. At the onset of the thesis, I quoted from a novel by Winterson (1996 p89) that “[w]ritten on the body is a secret code only visible in certain lights; the accumulations of a lifetime gather there”. The various ‘sediments’ of experiences regarding bodies has been a thematic interest throughout my research and, in addition, I perceive there to be a parallel in terms of conducting research and writing. To close by reworking the earlier opening quotation: written in this thesis are attendances only articulable through certain frames; the accumulations of my research gather here.

Appendices

Appendix 1: Vignettes of Participants

Anne, now in her mid-thirties, experienced two pregnancy losses: one miscarriage estimated about five to six weeks gestation and one stillbirth at full term. Anne and her husband experienced difficulties conceiving these pregnancies, with the probable cause pertaining to her endometriosis. Anne's second pregnancy became overdue and she began to leak small amounts of amniotic fluid, though this was dismissed when she spoke on the telephone to medical staff. After a visit from her midwife, she was referred to the maternity unit for foetal heart monitoring but then sent home as the observations were deemed normal. However, Anne began feeling very ill that evening with strong contractions and she returned to the maternity ward where a foetal heartbeat could not be found. Foetal death was diagnosed and Anne was slowly induced a couple of hours later, giving birth the following evening. The post-mortem results did not yield a definite cause but suggested several options, relating to the fact that the pregnancy was overdue and the warning signs of amniotic leaking had not been addressed, that either the placenta malfunctioned or that the leaking of amniotic fluid over several days had allowed an infection to set in.

Ben, now in his mid-twenties, spoke about his sister's pregnancy which culminated in the stillbirth of Ben's niece about a decade ago. Ben had not had much contact with his sister during her pregnancy or the birth owing to living some distance away. As such, Ben mostly spoke about the experience of attending the funeral and the ways in which he and his family have since incorporated the memory of his niece into their lives, including by visiting her grave and shared conversations. A teenager at the time of the occurrence, Ben recalled his mother explaining the term 'stillbirth' but there had been little further discussion beyond this. Although the cause of the pre-partum foetal death was inconclusive from autopsy reports, there was some speculation that it could be related to alcohol consumption during the pregnancy. This was the first bereavement Ben had experienced of a "young person" and his response was simultaneously sad and compassionate yet confused and ambivalent.

Beth, after a successful first pregnancy resultant in her now-toddler child, experienced a miscarriage in her second pregnancy at nine weeks gestation. The

second pregnancy had been planned and quickly conceived, but Beth had concerns as it progressed. She contrasted her symptoms to those of her first pregnancy which had required hospitalisation for rehydration with severe morning sickness and gestational diabetes. Owing to this latter condition, Beth had to monitor her blood sugar levels and this out-of-the-ordinary behaviour was noted by her colleagues as indicative of her pregnant status for which she then had to “untell” following the miscarriage. Beth began bleeding and visited her General Practitioner (GP) aware that, as a medical professional herself, this constituted a threatened miscarriage. The bleeding became heavier, culminating in the eventual passing of the foetal sac at her home. Beth, now in her mid-thirties, was pregnant at the time of her initial participation in the research and continued with email interviews following a successful birth.

Carla experienced multiple pregnancies and pregnancy losses, with her first pregnancy resultant in her living child, followed by two miscarriage and three terminations. Now in her mid-twenties, Carla had been under the legal age of consent when she became pregnant for the first time. Both of her miscarriages were of wanted pregnancies, with the first around 12 weeks gestation and the second estimated between eight to 10 weeks. In both instances, she attended hospital for ultrasonography scans and possible treatment. The circumstances of her three medical terminations, all estimated around five to six weeks, included being unable to cope with a second child at that time, a sexual assault and learning of her partner’s infidelity. Carla’s experiences clearly included some traumatic aspects and she repeatedly conveyed the coping strategy of trying to “just ignore it”. This ethos conflicted somewhat with the openness with which she spoke in the first research interview, although it later became evident that a second interview would not be possible. Without clarification, since contact from Carla stopped, I speculate that this may have been owing to a reluctance to ‘revisit’ her distressing experiences and/or embarrassment about previously rescheduling interviews and a missed meeting.

Caroline, with her first miscarriage occurring in the late 1990s during her early thirties, experienced a total of four miscarriages after the successful births of two children. These earlier two pregnancies were “very straight forward” and it was a significant shock to Caroline when her first miscarriage was diagnosed at a routine ultrasonography scan. Caroline conceived again, feeling that the

chances of a second miscarriage were unlikely; however, intrauterine death estimated at nine weeks was diagnosed by scan. Her third miscarriage was also discovered in this way at around seven weeks. All three of these miscarriages were managed surgically by Dilation and Curettage (D&C). In an ultrasound scan at 10 weeks of Caroline's sixth pregnancy, her fourth miscarriage, a foetal heartbeat was present but a bleed around the sac was evident. Caroline saw this as a looming indicator and when she began bleeding, she refused to return to hospital and instead miscarried at home. With her four miscarriages occurring over a period of several years, Caroline struggled to secure appropriate medical investigation and she researched possible causes for her recurrent miscarriages. Although a diagnosis of antiphospholipid antibodies (APS) was eventually given and treatment made available, Caroline did not conceive again.

Diane experienced seven miscarriages in addition to having three living children. The distress of these had been a source of dispute in Diane's marriage at times. Five of her early miscarriages were medically confirmed, with three treated by surgical management (D&C) and two by medical management (tablets). The other two miscarriages were detected with home pregnancy tests but ended naturally before she had been able to get an appointment with her GP to confirm the results. Her first miscarriage, after the live birth of her first child, was confirmed by ultrasound at 12 weeks gestation and was followed by two subsequent miscarriages before APS was diagnosed. Diane was referred for treatment—heparin sodium injections and low-dose aspirin—and after two additional miscarriages, she had her second living child. Diane miscarried twice more, with the final (seventh) miscarriage diagnosed via ultrasound. She had wanted to allow this last one to miscarry naturally but was encouraged to have surgical management to minimise infection risk. Her last (tenth) pregnancy resulted in the live birth of her third child, also supported by the treatment of heparin and aspirin to inhibit excessive blood coagulation.

Esther, now in her early thirties, became pregnant for the first time whilst undergoing fertility treatment with the ovulation-inducing hormone Clomid. Esther conceived in her first cycle using this drug but, following a visit to her GP to confirm the pregnancy, was referred on to the hospital with a suspected ectopic pregnancy. Although this was promptly ruled out, the dropping levels of human chorionic gonadotropin (hCG) in the blood tests taken, revealed by a

doctor on the telephone, suggested Esther's pregnancy had probably ended at just under seven weeks gestation. In the process of seeking confirmation of this, Esther underwent multiple blood tests and scans with long waits in the hospital and questions from medical staff which assumed bleeding had already occurred when it had not. After miscarrying naturally, Esther underwent eight additional cycles on Clomid but had not, at the time of the last interview, conceived again and she and her husband were embarking on the process of adoption.

Fiona, now in her late twenties, conceived her second pregnancy unknowingly whilst trialling contraceptive pills to find her preference. She developed pre-eclampsia in her first pregnancy, requiring Fiona to be intensely monitored and hospitalised for bed rest during the latter months. Although she gave birth naturally at full term, her new-born stayed on a Neonatal Intensive Care Unit (NICU) ward for over a week before being allowed home. It was retrospective to the occurrence of her miscarriage that Fiona recognised that she had been experiencing pregnancy symptoms, previously deemed fatigue from everyday caring for her young child. After feeling some intense pains in her abdomen throughout the day, Fiona collapsed whilst home alone with her toddler and, only able to get up after several minutes later, felt the passage what she later identified as an embryo estimated around eight to nine weeks gestation. Heavy bleeding ensued, eventually tapering out, and Fiona telephoned the NHS in which a doctor reiterated her assessment that it had been a miscarriage. She attended a GP appointment several days later, but found the GP's examination and engagement severely lacking; subsequently most of Fiona's medical understandings were derived from her own diligent searches online.

Gemma, now in her late twenties, conceived for the first time with an unplanned pregnancy in her early twenties. Although the pregnancy was unexpected, Gemma and her partner were in a stable relationship and became increasingly excited about having a baby. With a routine scan at 12 weeks, her pregnancy was progressing well but an anomaly scan at 21 weeks gestation clearly showed foetal spina bifida. Gemma and her partner were faced with the traumatic decision to continue the pregnancy—knowing that the baby would have potentially severe brain damage owing to swelling, limited mobility and incontinence—or to terminate the pregnancy. Although ambivalent in speaking about the decision, the latter was ultimately settled upon and Gemma attended

hospital to be induced and deliver several days later. The highly medically-managed and medicated termination birth in hospital was in sharp and deliberate contrast with Gemma's two subsequent (live) home births.

Graham, now in his early thirties, spoke about his and his wife's experiences of 11 miscarriages. All but one of these occurred before the 12 week gestation mark, with the majority identified between six and eight weeks, including one ectopic which was resolved medically and without the removal of a fallopian tube. Three or four of these miscarriages were managed surgically via Evacuation of Retained Products of Conception (ERPC), one medically, and the others naturally. The latest miscarriage, identified at 12 weeks, had been managed surgically. With a prolific number of pregnancy losses stretching across several years, Graham noted how there was a sense in which "it all rolls into one after a little while". Graham was acutely frustrated by the inadequate attitudes and dismissive treatment from medical staff as well as from some of his wider social group towards him as a male partner. Medical causes for the miscarriages had not been officially confirmed and, in the absence of medical advances which might enable them to biologically have living children, Graham and his wife were in the process of becoming adoptive parents.

Helen, now in her late thirties, miscarried her first pregnancy before successfully birthing her two living children. Shortly after learning she was pregnant, after a series of inconclusive or otherwise unclear home-kit tests, Helen began spotting and visited 'Accident and Emergency' (A&E) later in the day to seek medical assistance. An internal/transvaginal scan yielded no definitive answers and another abdominal scan was booked for a few days later. However, an internal scan was needed, showing an embryo sac but a heartbeat could not be found – although, because of the early stage of pregnancy, this was not necessarily indicative of an ended pregnancy. Across several weeks, with multiple blood tests and another inconclusive scan during this time, there remained uncertainty as blood results initially indicated a progressing pregnancy. Finally, a fourth scan revealed the embryo sac to be empty and Helen's miscarriage was medically managed with pessaries administered in hospital before she was sent home once bleeding ensued. Helen expressed some remorse about the extent to which she had been affected by her miscarriage at

the time of occurrence and commented that it had not been the “event and drama” previously anticipated, with relatively minimal blood loss and pain.

Holly, after several months of trying to conceive with her husband, became pregnant for the first time in her early thirties. However, between nine and 10 weeks gestation, Holly began to experience some spotting. After speaking to her husband, whose occupation was as a GP, she attended A&E where she was dismissively treated and sent home with little clarity on her suspected miscarriage. After several days of waiting, with the onset of heavy bleeding and pain, Holly felt the passage of the embryo body as she naturally miscarried. The physically and emotionally painful experience of her miscarriage remained a source of anxiety throughout her second pregnancy, which she had conceived soon after the miscarriage. This second pregnancy was ongoing at the time of the research interviews and culminated in the live birth of her child.

Isabel, now in her late thirties, experienced two miscarriages in between two successful pregnancies. Isabel’s first miscarriage occurred at 10 weeks with the onset of bleeding for which an ultrasonography scan several days later indicated no visible trace of the pregnancy remaining. Her second miscarriage was unexpectedly diagnosed at a 20 week anomaly scan, after the previous 12 week routine scan had been promising. A few days later, Isabel was induced and delivered the baby in hospital. Under the encouragement of an attending doctor, Isabel declined to see the baby once delivered, although the hospital took some photographs to be kept in her medical record in case she later wanted access to them. The hospital helped organise a funeral which Isabel attended with her sister. Several months later, the post-mortem indicated that, during her pregnancy, Isabel had been in contact with Parvovirus and that this had crossed the placenta with teratogenic effects. Around six months later, Isabel conceived her fourth pregnancy, culminating in her and her husband’s second living child.

Jane, in her early thirties, attended a routine 12 week ultrasonography scan in her second pregnancy, revealing it to be anembryonic and that it had not progressed past three or four weeks. Her first pregnancy had been relatively straightforward, with minimal morning sickness, in contrast to the more intense feelings of nausea and exhaustion in her second pregnancy. Jane attended an appointment the day after the scan to discuss miscarriage management options although, with online research the prior evening and some knowledge from her

medical professional background, she was already inclined towards the surgical option. Discharged after the ERPC, she continued to bleed for some weeks which, combined with her pre-existing irregular menstrual cycles, she found highly frustrating. During the course of participating in the research, Jane fell pregnant for a third time, providing multiple updates on the progression of her pregnancy and reflecting on the ways in which her previous miscarriage influenced her current experience. Jane contacted me shortly after our last interview exchange to inform me of the live birth of her new-born.

Lara, now in her mid-twenties, experienced her first two pregnancies in relatively quick succession, both of which were unplanned. Her first pregnancy ended in natural miscarriage at around five weeks, with the onset of bleeding and confirmation by ultrasound that the miscarriage had been complete. Her second pregnancy was terminated, at around the five week gestation point. This was by vacuum aspiration as this was the only option offered in the hospital attended in her home region of East Asia, in contrast to medical termination with tablets/pessaries which would likely be the management method for this situation in the UK. During the course of our second interview, Lara voiced her suspicions that she was pregnant for a third time—a concern which had re-evoked memories from her previous miscarriage and termination experiences—although test results several days later from her GP later indicated that she had not been and her belated menstrual period promptly resumed.

Lisa, now in her early forties, experienced two miscarriages over a decade ago. The pregnancy of the first miscarriage had not been confirmed by hCG test and Lisa's GP had been dismissive, suggesting that she had experienced no more than a delayed menstrual period contrary to Lisa's certainty. Her second miscarriage occurred around the nine to 10 weeks gestation mark, indicated with some spotting for which she attended hospital and a transvaginal scan indicated that only an empty embryonic sac remained. Lisa was prepped for a D&C the following day but whilst awaiting the operation, she felt the passage of the sac. Lisa still underwent the surgery to be sure the miscarriage was complete but she suffered an allergic reaction to the anaesthetic, making her very unwell and requiring overnight supervision at the hospital. Her third pregnancy culminated in the birth of her living child, although this pregnancy had been

anxious and difficult owing to complications such as developing gestational diabetes, a prolonged labour and premature birth.

Marie, now in her mid-thirties, began trying to conceive with her husband after his vasectomy reversal, discovering a couple of months later that she was pregnant. However, the 12 week routine scan showed an empty embryo sac, diagnosed as an anembryonic pregnancy, for which Marie underwent a D&C a fortnight later. During this time, analysis results from a sample of her husband's semen returned as fully immotile. Nonetheless, Marie conceived a second time but some spotting began around six weeks in, which her GP suggested it would likely be implantation bleeding. However, the bleeding became heavier with cramping and Marie passed the pregnancy tissue subsequently. Several months later, Marie discovered she was pregnant for a third time but after a promising early viability scan around six weeks, a private scan at nine weeks revealed a missed miscarriage which was managed by a second D&C. During the course of her participation in the research, Marie fell pregnant which she said was progressing well at 27 weeks in the last interview.

Natalie, now in her late thirties, experienced two miscarriages: the first occurring after the birth of her eldest child and the second miscarriage following that of her second living child. Both successful pregnancies had also entailed complications, with major (grade four) placenta praevia in the first and a significant bleed during the pregnancy with her second living child. Natalie's first miscarriage was diagnosed around 14 weeks, although she had been experiencing some bleeding for a fortnight previously. The second miscarriage was estimated at around six weeks gestation. For both miscarriages, Natalie underwent medical management but continued to experience bleeding for over a month after the ERPC for the second miscarriage and she was given a scan which showed remaining pregnancy tissues. Subsequently an additional ERPC was performed and it was discovered that one of the previous operations had created a false passage. As a result, Natalie had been unwell, requiring frequent hospital visits, across an extended period of several months. During the course of the research, she continued to have some related health problems with ongoing medical investigations regarding the false passage.

Penny, after the successful birth of her two children, fell pregnant for a third time after agreeing with her husband that they would like to try for another

child. It became evident instantaneously to Penny at the 12 week ultrasonography appointment, given her scan experiences with the previous pregnancies, that there was something wrong. With an additional member of personnel brought in, medical staff members were unable to find a heartbeat and the measurements suggested that the embryo had stopped developing between eight and nine weeks. Retrospectively, Penny identified divergences in the symptoms of the miscarried pregnancy to her previous two successful pregnancies. A day or so after the scan, Penny underwent surgical management. Although she had relatively little bleeding after the ERPC, she had since continued to experience some physical health problems, including multiple urinary infections. Penny planned to have the ashes of her miscarriage located to a nearby baby memorial garden which she had visited a number of times.

Rosie, now in her mid-thirties, spent several years trying to conceive with her husband before becoming pregnant for the first time. This pregnancy, however, was diagnosed as ectopic and required the removal of one of her fallopian tubes. Following this, Rosie underwent IVF treatment, resulting in two biochemical pregnancies ending before conceiving a fourth time. However, Rosie began to bleed and she attended hospital for an ultrasound scan where a heartbeat was detectable but the medical staff had grave concerns. Rosie continued to visit the hospital for weekly scan appointments, with there seeming to be progress at eight weeks. The subsequent scan, however, did not yield a heartbeat and Rosie underwent an ERPC the following day. Diagnosed with polycystic ovary syndrome (PCOS), Rosie, at time of participating in the research, had a forthcoming IVF cycle booked whilst she and her husband were also in contact with an adoption agency. Since the adoption process would require her to have been finished with IVF for one year minimum and one embryo remained ready for implantation, Rosie was torn between deciding the next step.

Siobhan, now in her early twenties, participated in the research to talk about the neonatal death of her new-born nephew following her sister's delivery of twins. Siobhan had researched the likelihood of neonatal death following the diagnosis of a rare genetic disorder on behalf of her sister and she was closely involved in the labour and delivery of the babies as birth partner. Owing to the circumstances of the delivery, Siobhan held the baby for the majority of his short 45 minute life span whilst her sister delivered the second baby and had the

removal of an epidural catheter. The baby died shortly after being christened. During the stay in the hospital, Siobhan and her sister were able to spend some time with the deceased baby, struggling with the simultaneous joy and sadness of the arrival of the twins. A funeral with an accompanying wake was held following an autopsy regarding which Siobhan had also attended a meeting about in order to support her sister's comprehension of the findings.

Tania, having had two successful pregnancies, experienced her first miscarriage in her third pregnancy at around 13 weeks gestation. Although the pregnancy had been unplanned and there had been some uncertainty about continuing it, Tania and her husband became increasingly excited about the news. However, with some initially light bleeding progressively becoming heavier and more painful, Tania attended hospital. Within a few minutes of arrival, she felt the passage of the pregnancy material and subsequently underwent a D&C to complete the miscarriage. The hospital arranged a funeral, having taken a non-committal response from Tania at the time to indicate a request to do so, which Tania reluctantly attended with her husband. Whilst this was a deeply distressing occasion, she felt that attending had provided "much peace afterwards". Speaking about her experiences in the research proved to be more difficult than Tania had initially anticipated, leading us to agree indefinite suspension of her participation in the interviews until further notice.

Tessa was the only participant in the research whose experiences occurred entirely outside of the UK, living in southern Africa and having heard about my research in UK-based pregnancy loss websites and support communities which she had visited. Subsequently, there were some noticeable differences in the health care system described but also similarities pertaining to the fact that Tessa received high quality, private hospital care. Now in her late twenties, Tessa experienced a miscarriage in her first pregnancy, following some spotting which worsened, requiring a visit to her doctor. The next day, an ultrasonography scan was performed at nearly 16 weeks and revealed that the foetus had died. A D&C was scheduled for the next day, though this wait added to the traumatic knowledge that the pregnancy had likely ended two or so weeks before the onset of bleeding. Tessa bled heavily after the operation and was kept in the hospital for observations out of concern that she might haemorrhage.

Tessa was pregnant for a second time during the course of the interviews, progressing well at 28 weeks at the time of our last interview exchange.

Victoria, now in her late thirties, experienced two miscarriages around six weeks gestation after a successful birth. In the first miscarriage, Victoria had progressively heavier bleeding and an ultrasonography scan revealed no heartbeat. Victoria was sent home to miscarry naturally, only passing the sac nearly a fortnight later. Victoria suspected that she was pregnant for a third time a few weeks later and visited her GP who, on learning that she had some pain in her side, referred her to an Early Pregnancy Unit (EPU) for a scan. The medical staff there were dismissive, reproaching that she could not be pregnant and still have had such a recent menstrual period, and sent her home after commenting that they could tell little from the scan. She returned to the EPU a week later, hoping for a clearer answer on whether she was pregnant, to be told that she had a six week ectopic pregnancy and required urgent surgery. Victoria was sent home after the operation which entailed the removal of one fallopian tube. The scars continued to cause discomfort and Victoria was very anxious about conceiving again, which she did whilst the research was ongoing.

Appendix 2: Summary of Interview Modes of Communication

Participant Pseudonym	Modes (and Number) of Interview Communications From Participant
Anne	Telephone (2)
Ben	Skype (1) and email (1)
Beth	Email (5)
Carla	Face-to-face (1)*
Caroline	Telephone (2)
Diane	Email (10)
Esther	Telephone (2)
Fiona	Email (8)
Gemma	Email (1) and face-to-face (1)
Graham	Email (6)
Helen	Email (5)
Holly	Face-to-face (2)
Isabel	Email (3) and telephone (1)
Jane	Email (11)
Lara	Face-to-Face (2)
Lisa	Email (5)
Marie	Email (2) and telephone (1)
Natalie	Telephone (2)
Penny	Email (2)
Rosie	Telephone (2)
Siobhan	Face-to-face (2)
Tania	Email (1)**
Tessa	Email (7)
Victoria	Email (6)

* Contact from participant then ceased without notice

** Indefinite suspension of participation in the interviews agreed

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